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CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1990

HEARINGS

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

COMPETITIVENESS

JANUARY 17, 1989

STATUS OF THE FEDERAL DEPOSIT INSURANCE CORPORATION

MARCH 2, 1989

HUMAN RESOURCES

MARCH 8, 1989—PRESIDENT BUSH'S PROPOSALS FOR HHS MEDICARE

Volume II of III

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COMPETITIVENESS

TUESDAY, JANUARY 17, 1989

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee convened, pursuant to notice, at 10:12 a.m., in room SD-608, Dirksen Senate Office Building, Hon. Jim Sasser (chairman of the committee) presiding.

Present: Senators Sasser, Riegle, Sanford, Conrad, Gramm, and Bond.

Staff present: John L. Hilley, staff director; and Douglas Cook, assistant director for national security and foreign affairs.

For the minority: G. William Hoagland, staff director; and Gail Fosler, deputy staff director and chief economist.

OPENING STATEMENT OF CHAIRMAN SASSER

Chairman SASSER. The committee will come to order.

I want to welcome our witnesses hear today and welcome interested parties who are here to hear this very important testimony, to welcome my colleagues Senator Conrad and Senator Riegle, and to announce that our distinguished ranking member, Senator Domenici, will not be with us today. He underwent some emergency oral surgery yesterday, and he is doing well, but he called in and said that he just did not feel up to getting over here this morning, and I can certainly understand that.

We will be joined shortly by some of our distinguished colleagues on the minority side, but in the interest of saving time, we are going to go ahead here this morning.

This is the first hearing of the Budget Committee of the 101st Congress, and I look forward to some very productive hearings and work during the course of this year.

Today, we are going to be looking at the country's fiscal policies in the broadest context. We will be examining their deepest implications both for ourselves and for future generations.

Maybe the best way to frame the issue is to consider a point of view that is dominant in some quarters right now. Many people are saying that we have been running triple-digit deficits for the better part of a decade and that the "gloom and doomers" have been waiting for the sky to fall at least for that long, but that it hasn't happened.

We have had sustained growth, so the story goes; inflation has been held in check, and so their argument runs that there is just a lot of hysteria out there. What, after all, they say, is the big fuss if deficits haven't hurt us thus far.

Well, today we are going to get an answer to that question. We are going to get it from some of the country's most distinguished business, labor and educational leaders.

The Council on Competitiveness is composed of the chief executive officers of some of the Nation's largest corporations, representatives of our major national labor unions, presidents of some of the finest institutions of higher learning in the country.

It is a group that crosses over all party lines, all ideological lines, and of course, all geographical boundaries in the country. It is not accidental that the individuals who constitute the Council for Competitiveness are so sensitive to America's prospects for the years ahead, because they are some of the most perceptive observers of the fault lines that may lie beneath the otherwise placid surface of our economy.

Let me say at the outset that the Council has performed, I think, an extraordinary public service. Its report isolates the central forces that are currently eroding America's economic foundation, and if I might just point out some of the observations in advance, the overriding fact of America's domestic scene is that our current prosperity is being purchased at the expense of our resources for the future. So says the Council.

If the American standard of living is declining due to a lack of investment in our industrial, our education, our physical and our human infrastructure, the elements of that threatening condition are, as I read the report, a national debt that has tripled in the last 8 years to some $2.8 trillion—and that is consuming 15 cents of the Federal dollar in annual debt service. The Federal debt, excluding social security, is continuing to increase. The personal savings rate that is less than a small fraction average than that of major industrialized nations has fallen from a rate of 7 percent in 1980 to a personal savings rate of only 3 percent today. A reliance on foreign capital has reached the level of some $10 billion per month in investment from abroad.

It is not too much to say that these are the characteristics of a world power potentially in decline. The fact that the United States finds itself in such a precarious position explains in no uncertain terms why there is so much fuss and controversy about the enormous budget deficits that we have run up in recent years.

Today we are very fortunate to have two very distinguished members of the Council on Competitiveness to explore the issues I have just laid out and to offer us a range of potential solutions.

Before hearing any opening statements from my colleagues, I do want to welcome Mr. John Ong, Chairman of the Board of B.F. Goodrich and Dr. Joseph Duffey, Chancellor of the University of Massachusetts.

Gentlemen, we welcome you, and before getting into your testimony, I want to return now to my colleagues for any opening statements they might wish to make.

I want to first recognize our distinguished colleague from Texas, Senator Gramm. I want to welcome you to the Budget Committee, Senator Gramm. We now have on the Budget Committee all that famous trio of Gramm, Rudman, and Hollings. So welcome to the committee, Senator Gramm, and we look forward to any observations you might have to make today.

OPENING STATEMENT OF SENATOR GRAMM

Senator **Gramm**. Mr. Chairman, let me thank you for recognizing me.

I would like to begin by asking unanimous consent that a statement by our distinguished ranking member, Senator Domenici, be put into the record. And I would like to add, Mr. Chairman, that I am delighted to be here rather than where he is this morning having had oral surgery. I think it would be appropriate with you as our new Chairman if I read the first page of his opening statement, and I hope that you will bear with me, Mr. Chairman.

"Before I welcome our witnesses, I would like to publicly congratulate Senator Sasser on becoming Chairman of this committee. In the history of this committee, you were the fifth Senator to hold the chairmanship. Unfortunately for me, the chairmanship has rested four times on your side and only once on ours. Since I was that one on our side, Mr. Chairman, I can tell you, you have a thankless task."

"But you and indeed, the entire committee, have a most important task as we help to mold the fiscal policy of this great country. I look forward to working with you, Mr. Chairman, as we confront the problems, challenges and opportunities that face this country."

Mr. Chairman, I ask unanimous consent that Senator Domenici's entire statement be made part of the record.

Chairman **Sasser**. It will be included in the record.

[The prepared statement of Senator Domenici follows:]

OPENING STATEMENT
COMMITTEE ON THE BUDGET
COUNCIL ON COMPETITIVENESS

Senator Pete V. Domenici

January 17, 1989

BEFORE I WELCOME OUR WITNESSES, I WOULD LIKE TO PUBLICLY CONGRATULATE SENATOR SASSER ON BECOMING CHAIRMAN OF THIS COMMITTEE. IN THE HISTORY OF THIS COMMITTEE, YOU ARE THE FIFTH SENATOR TO HOLD THE CHAIRMANSHIP.

UNFORTUNATELY FOR ME THE CHAIRMANSHIP HAS RESTED FOUR TIMES ON YOUR SIDE, AND ONLY ONCE ON OURS.

SINCE I WAS THAT ONE ON OUR SIDE, MR. CHAIRMAN, I CAN TELL YOU, YOU HAVE A THANKLESS TASK. BUT YOU, AND INDEED THE ENTIRE COMMITTEE, HAVE A MOST IMPORTANT TASK AS WE HELP TO MOLD THE FISCAL POLICY OF THIS GREAT COUNTRY.

I LOOK FORWARD TO WORKING WITH YOU, MR. CHAIRMAN, AS WE CONFRONT THE PROBLEMS, CHALLENGES, AND OPPORTUNITIES THAT FACE THIS COUNTRY.

I --- ALL OF US ON THE MINORITY SIDE OF THIS COMMITTEE --- ARE COMMITTED TO WORKING WITH YOU AND THE MAJORITY MEMBERS OF THIS COMMITTEE.

I KNOW THAT YOU FULLY UNDERSTAND, HOWEVER, MR. CHAIRMAN, THAT THERE WILL BE DIFFERENCES OVER THE OPINIONS ON POLICIES AND SOLUTIONS WE CONFRONT. THOSE WILL BE HONEST DIFFERENCES OF OPINION. IT IS MY HOPE AS WE BEGIN THIS CYCLE, THAT THE POLITICAL DIFFERENCES CAN BE MINIMIZED.

TURNING TO THIS HEARING, YOUR FIRST, MR. CHAIRMAN, I JOIN YOU IN WELCOMING THE WITNESSES THIS MORNING. MR. CHAIRMAN, I'VE HAD THE OPPORTUNITY TO HEAR THE COUNCIL'S PRESENTATION BEFORE. ITS CHAIRMAN, JOHN YOUNG OF HEWLETT-PACKARD COMPANY, TESTIFIED BEFORE THE NATIONAL ECONOMIC COMMISSION IN LATE NOVEMBER.

I WAS INTRIGUED AND PLEASED WITH THE COUNCIL'S PROPOSAL THAT WE ESTABLISH SPENDING CAPS ON DEFENSE AND NONDEFENSE DISCRETIONARY APPROPRIATIONS AND ON ENTITLEMENTS. I WAS ALSO PLEASED WITH THE COUNCIL'S FOCUS ON SHIFTING SPENDING PRIORITIES TOWARD SCIENCE, TECHNOLOGY, AND EDUCATION. THESE POLICIES WERE INCLUDED IN PRESIDENT REAGAN'S BUDGET A WEEK AGO, SUCH AS DOUBLING THE NATIONAL SCIENCE FOUNDATION'S BUDGET OVER THE NEXT FIVE YEARS.

WHILE YOU WILL FIND STRONG SUPPORT FROM THIS SENATOR ON THESE INITIATIVES, I MUST SAY, WITH ALL RESPECT TO THE COUNCIL, THAT ITS RECOMMENDATIONS FOR FINANCING THESE INITIATIVES FOCUS TOO HEAVILY ON THE REVENUE SIDE. I NOTE THAT THE TESTIMONY THIS MORNING MENTIONS REVENUES ONLY IN PASSING WITH FEW SPECIFICS.

MY RECOLLECTION, FROM PREVIOUS TESTIMONY, IS THAT THE COUNCIL PROPOSES A 20 CENTS-PER-GALLON INCREASE IN THE GASOLINE TAX, A BROADENED INDIVIDUAL AND CORPORATE TAX BASE, RAISING INCOME-TAX RATES FOR UPPER-INCOME FAMILIES, AND IMPOSING A TEMPORARY SURTAX ON INDIVIDUAL INCOME. IF I AM WRONG ON THIS, I'M SURE THE WITNESSES WILL CORRECT ME IN THEIR TESTIMONIES.

I COMMEND THE COUNCIL'S PROPOSALS FOR CUTTING SPENDING. BUT I SUGGEST THAT THE COUNCIL HAS NOT GONE FAR ENOUGH. IF WE WERE TO SIMPLY FREEZE BUDGET AUTHORITY AT CURRENT LEVELS -- FOR BOTH DEFENSE AND NONDEFENSE PROGRAMS -- WE COULD ACHIEVE $73 BILLION IN BUDGET SAVINGS BY 1993.

THESE SAVINGS ARE ON DISCRETIONARY PROGRAMS ONLY. IF WE WERE TO ADD JUST HALF OF PRESIDENT REAGAN'S ENTITLEMENT SAVINGS, WE WOULD HAVE JUST UNDER $100 BILLION IN SPENDING SAVINGS ALONE. THIS COMPARES TO THE COUNCIL'S $48 BILLION IN SPENDING SAVINGS.

YES, THIS WOULD BE DIFFICULT. YES, IT WOULD MEAN THAT SOME PROGRAMS MIGHT BE CUT IN REAL TERMS UNLESS THEY WERE MADE MORE EFFICIENT. NO, IT DOES NOT MEAN THAT WE COULD NOT ADD ANY NEW PROGRAMS. THIS ONLY MEANS THAT WE WOULD HAVE TO PAY FOR NEW INITIATIVES BY ELIMINATING OLD PROGRAMS.

I DON'T KNOW IT FOR A FACT, BUT I SUSPECT YOU DEMAND MORE OF YOUR OWN MANAGEMENT THAN I HAVE SUGGESTED WE DEMAND OF THE FEDERAL GOVERNMENT.

I MAKE THIS POINT BECAUSE I BELIEVE, IF WE DON'T USE THIS YEAR'S OPPORTUNITY TO CUT THE CURRENT UNNEED PROGRAMS OF GOVERNMENT AS MUCH AS IS POSSIBLE, BUSINESSMEN LIKE YOU WILL BE BACK HERE IN THE NOT TO DISTANT FUTURE COMPLAINING OF THE TAXES AND MANDATED REQUIREMENTS THAT THE FEDERAL GOVERNMENT HAS IMPOSED ON YOU TO MEET THE NEW NEEDS WE HAVE IN THIS COUNTRY.

MR. CHAIRMAN, THE TRADE-OFF BETWEEN TAXES AND SPENDING IS CONSIDERED BY MANY TO BE THE CRUX OF THE BUDGET DEBATE THIS YEAR. RATHER, THE DEBATE SHOULD CENTER ON THE TRADE-OFF BETWEEN THE NEW NEEDS OF THIS NATION AND THE MANY, OLD PROGRAMS THAT HAVE EITHER OUTLIVED THEIR USEFULNESS OR COULD BE MADE MUCH, MUCH MORE EFFICIENT.

I LOOK FORWARD TO THE TESTIMONY FROM OUR WITNESSES.

Senator **Gramm**. Mr. Chairman, I will be brief.

Mr. Chairman, there is no doubt about the fact that we face great challenges in sustaining a recovery that now is in its 73d month. Clearly, the deficit is too large. I believe Federal spending is still too large, despite the fact that the growth rate has been roughly reduced by 50 percent in the last 3 years as compared to the previous two decades. Also there is no doubt, Mr. Chairman, that we are highly dependent on foreign capital, partly because of extraordinarily high interest rates due to Federal absorption of available capital, in part because we have the fastest-growing, most productive, most profitable economy in the world.

While we are hanging out all of the black paper for the economic funeral, I think it is important to remember, however, that no nation on earth has created more jobs than we have since 1982. We have created more jobs than all of our industrial trading partners put together. The American economy is fundamentally strong and is sustaining its strongest period of economic recovery in American history. In 8 years, we have practically brought the inflation rate to a standstill, we have cut interest rates by two-thirds, and we have ignited one of the most rapid expansions in American history.

Our economy, in my opinion, far from being in decline, is the envy of the world, and America, far from being in a position of declining power today sees its principal adversary in economic and social disarray. So I certainly concur with our distinguished Chairman that there are great challenges that face this committee. But I do not concur that there is any evidence whatsoever to substantiate any claim that America is in decline, that our economy is in shambles, that we lack the tools in any way to deal with this problem.

The plain truth is that the economic recovery which is underway is our greatest asset in dealing with the deficit problem. This year, without any increase in tax rates, without the imposition of any new taxes, some $80 billion in new revenue will come through the front door of the Federal Government as a result of the economic expansion that is underway.

The Gramm-Rudman-Hollings law requires that about $50 billion of that $80 billion be applied to reduce the deficit, which means that we will have $30 billion more to spend this year without a tax increase, after having met our deficit reduction target. That converts roughly into a 3-percent growth in Federal spending as compared to last year's spending, and while that may be difficult and no doubt will tax our abilities and our patience and probably our political courage, I do not think that the average citizen or the average family or the average business in this country would consider 3 percent spending growth cruel and inhumane punishment.

In my part of the country, where we have not shared in the prosperity for the last 3 years, there are few families and few businesses that have had the burden of simply limiting the rate of growth of their spending to 3 percent. Most of them have had to tighten their belts and actually reduce outlays as compared with the year before. That is something that we do not have to do.

And Mr. Chairman, I look forward to working with you and the entire committee to try to address this task, and I am greatly honored to have a chance to serve on this committee.

Chairman **Sasser**. Thank you, Senator Gramm.

Senator Conrad.

OPENING STATEMENT OF SENATOR CONRAD

Senator CONRAD. Mr. Chairman, I would like to welcome our distinguished witnesses today. I read the commission's report last night and I think you have done an exceptionally good job framing the issues.

I feel some responsibility to reply to my valued colleague, Senator Gramm, because I think he has presented basically half of the story that we confront in this country.

He has only talked about the good news. He has not talked about how we built this base, a base built on quicksand.

The other side of the story is that in this period that he reports the good economic statistics, he left out some statistics. He left out that we have tripled the national debt in 8 years. He left out that we have multiplied the trade deficit sixfold. He left out that we have gone from being the biggest creditor nation in the world to the biggest debtor nation in the world. And he left out that the savings rate in this country has been cut in half.

The result of that set of statistics is that our economic sovereignty and indeed our control of our economic destiny is somewhat at risk. I think the report that you have prepared makes that quite clear, and I have questions that I'd like to pose after hearing from the witnesses.

Thank you, Mr. Chairman.

Chairman SASSER. Thank you, Senator Conrad.

Senator Riegle.

OPENING STATEMENT OF SENATOR RIEGLE

Senator RIEGLE. Thank you, Chairman Sasser.

I'd like to say at the outset that I think we are very fortunate to have you serve as the new chairman of this committee. I know from watching your service over 12 years in the Senate that you are going to do an outstanding job. This is a difficult assignment, I think its probably one of the most difficult in our Federal Government today, and I feel if anybody can meet this challange you are the one who can. So I feel very proud to serve on this committee with you.

I think it is significant as well that you have chosen to open the committee's deliberations today with a serious look at America's competitive performance in the world economy. Obviously, anything that we are going to have in the future, be it public or private goods—our private incomes, our private health insurance or our public expenditures for fighting drugs or our defense establishment—our entire national wealth, has to come out of our ability to produce each day as a nation.

Our competitive position in this new world economy is the key to our ability to have and maintain a decent standard of living for our people. And it seems to me that the Council on Competitiveness, continuing the work of the Presidential Commission on Competitiveness of several years ago, has done important work in its report and in putting its finger on a number of very disturbing trend lines that I think threaten our future. The suggestions that they have made, I think, are very important suggestions for us to consider, because unless we find a way to continue to make sufficient investment in our people and in our economic system, we are not going to be able to produce the kind of aggregate national income that we need to meet our public and private requirements.

So I think the committee is starting on exactly the right foot today in looking at this large question of how the country as a whole is doing in terms of its economic performance.

I want to say just one other thing, and that is that I appreciate, too, the fact that the commission points out that it is time to return to some honesty in the way we keep the accounting records of the Federal Government. Reference has been made to the Gramm-Rudman-Hollings deficit reduction discipline, and the fact is that that discipline works to create an artificial number and impression as to the size of the deficit. As the council reports in its work, the surpluses that are building up in the trust funds for Social Security and the other earmarked trust funds really hide the fact that the true operational deficit of this government is increasing—it is well over $200 billion for the current fiscal year—and while we go through the fiction of an accounting exercise to make the deficit appear to be lower than it is. Therefore to say that the Gramm-Rudman-Hollings discipline is working, is just untrue. The cold fact of the matter is—and any accountant in the United States will tell you—that a true adding up of the numbers of the performance of the government will show that our Federal Government deficit is well above $200 billion, and it could go far higher than that.

So we have a number of problems to solve, and I think it is very important that we give the most careful consideration to the recommendations of this very distinguished council.

Chairman SASSER. Thank you very much, Senator Riegle.

We have been joined by Senator Bond. Do you wish to make any opening comment, Senator Bond?

Senator BOND. Thank you, Mr. Chairman.

I will wait and perhaps ask some questions after we have heard the witnesses provide their testimony.

Chairman SASSER. Thank you.

Let me say to our distinguished witnesses that I want to congratulate you on the fact that you were able to reach a consensus among such a diverse political group. I hope the National Economic Council will take a leaf out of your book in their deliberations, and hopefully, they can reach a consensus.

In addition, I'd like to compliment you on your superb staff, led by Mr. Alan Magazine, ably assisted by Lisa Barry and Maggie Sheen.

The committee will listen today with special attention to any suggestions you might have for building a consensus here within the Congress and with the executive branch of government as we approach these very critical and crucial budget deliberations.

Mr. Ong, we will begin with you this morning. Welcome to the committee, and we look forward to your observations.

STATEMENT OF JOHN D. ONG, CHAIRMAN, B.F. GOODRICH CO., AND EXECUTIVE COMMITTEE MEMBER, COUNCIL ON COMPETITIVENESS

Mr. ONG. Thank you, Mr. Chairman.

My colleague, Joe Duffey, and I are very appreciative of the privilege of speaking to this committee and sharing our thoughts with you, and we look forward to an interchange of views.

We have a strong conviction that initiating a solution to the budget deficit problem is critical both to the short-term and long-term competitiveness of the United States. As you have seen in our report,[1] we feel deficit reduction is a matter of first importance in addressing the question of national competitiveness, although our report also goes on to point out some areas which we think require longer-term attention to ensure that our society moves forward and remains competitive on the world scene.

I am going to address myself to the budget deficit reduction recommendations that we have made, and then my colleague, Joe Duffey, will have some comments on our longer-term recommendations.

I have prepared a statement that has been submitted to the staff. I would appreciate it being entered into the record. At this point, I will try to summarize rather quickly some of the key elements in that prepared testimony.

Chairman SASSER. Your full statement will be included in the record as if read, Mr. Ong.

Mr. ONG. Thank you, Mr. Chairman.

Let me try to frame my comments around three topics. First, I'd like to say rather briefly why it is that the Council on Competitiveness feels that this issue of the deficit is so critical to the competitiveness of the United States. As you have pointed out, Mr. Chairman, despite the doomsayers some years ago, the growing size of the budget deficit has not resulted in an economic or financial catastrophe.

We would certainly agree with the observations that Senator Gramm has made regarding the vigor and durability of the American economy in recent years, and that economic performance has, as the Senator pointed out, been carried out during a period of very large and growing budget deficits.

We feel, however, that despite that fact, we are paying a very, very stiff price for this ongoing high budget deficit. Deficits have a negative effect on savings and investment in the economy and therefore, in the long run, on productivity growth. And without that productivity growth, we cannot hope to maintain, let alone build, higher living standards, which of course is our ultimate competitive new objective.

Net national savings during the eighties was only about 3 percent of GNP. That stands in contrast to an average since World War II of about 7 percent of GNP, and there are those who would argue with some force, that even that 7 percent represented an inadequate savings and reinvestment rate. Certainly, 3 percent is so low that it has resulted in stalled productivity growth in the country in recent years. And that stalling in our productivity improvement has allowed the economies of a number of our trading partner countries to catch up with us, perhaps even to surpass us in terms of productivity.

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[1] See p. 66.

We have been fortunate that there has been substantial foreign capital available to flow into the United States, to in effect finance this gap between our national savings and the required rate of investment. But again, the council feels that we pay a high price for that form of financing.

As was pointed out, foreign debt has become a very major factor, some $368 billion at the end of 1987, and we feel that while we can be grateful for the availability of foreign capital, it represents a problem that must be addressed over the long run.

In a nutshell, we feel that the deficit is a substantial handicap to increasing savings; increased savings and increased investment are critical to productivity improvement; and productivity improvement is the key to building the economy and building the ability of the country to maintain and increase living standards.

Let me then, second, switch to another topic and mention to you several convictions that the council derived as it studied this issue of the budget deficit over the past year. These convictions allowed us to gain a consensus among a body of which, as you have observed, is made up of people from many different elements of society with many different perspectives on national problems.

I think in some ways the most important conviction that we gained was that financing public spending by taxation is ultimately better than financing public spending by the deficit route. Financing Federal spending through higher taxes is obviously something which many people are concerned about. Businessmen clearly are not among those who readily recommend increases in taxation, as I am sure you are well aware.

But in very simple terms, it is our conviction that while taxation is some penalty to savings, it is also a penalty to consumption, whereas deficit financing is not a penalty to consumption but only to savings. And of the two, if that is the choice to be made, it is pretty clear that we are better off to have adequate tax funding for whatever level of spending the Congress and the Administration determines is required than to attempt to finance over the long term a substantial part of that spending by deficit finance.

A second conviction that we have, is that while strong economic growth is certainly very, very helpful—and I would agree strongly with Senator Gramm's observations on that score, we do not feel that that economic growth alone is sufficient to eliminate the deficit over any reasonable period of time. The task is simply too great to suppose that economic growth, and what it would imply in terms of revenue levels, is going to get the job done.

Third, to the point which Senator Riegle addressed a few moments ago, we feel very strongly that the country must face up to the full extent of the deficit problem. As the Senator observed, excluding the Social Security Trust Fund surpluses, the deficit seems to us clearly to be increasing, not decreasing. The Congressional Budget Office baseline numbers, which I would point out did not include funding for some more recently emerging problems such as the savings and loan crisis and the nuclear plant clean-up problem, indicated deficits in excess of $200 billion in the early 1990s. That is again, as I said, without the trust fund surpluses. And we feel that the Administration, the Congress and the country at-large need to face up to the problem in just those terms.

A fourth conviction that we have developed is that we have a unique opportunity—and here again, I would revert to Senator Gramm's comments about the vigor of our economy and the very long duration of the current growth cycle—we feel that, combined with recent successes in attacking the trade deficit, the relative value of the dollar versus other major trading currencies, gives the United States a unique, but probably relatively short-term "window of opportunity" to really address the budget deficit question. Corrections that are going to be meaningful, given the size of the budget deficit are obviously corrections which are taken at some peril to the economy. And clearly, with the progress that is being made in trade today, we feel there is an opportunity for those corrections to be applied without doing substantial harm to the economy. How long this window of opportunity will remain is of course something we don't know, but we feel that the Congress and the Administration should seize upon it and recognize that now is the time to take decisive action.

Finally, a fifth conviction that I would mention is the view that sequestration, which has been mentioned in some quarters as a solution to the deficit problem, is not really a viable option in our view. We feel it fails to address the structural cause of the budget deficit, and it merely postpones the tough choices that have to be made down the road.

Moving on, then, to a third area, let me just talk a little bit about some of the key points of the deficit reduction program which is contained in the report you have before you.

I think I would like to stress that in our judgment, our report is more important in terms of the broad themes that it addresses, rather than the specifics. We have made a number of specific recommendations, but we have tried to do so with suitable humility, understanding that this is a very complex area, there are many pressures and issues which you and others in the Congress and in the Administration must face in addressing this question. We have tried to show you a path that we think could be taken, but we do not for a minute feel that it is the only path and that our specific recommendations are the only ways to address it.

We do think, though, that the themes we highlight and the broad areas that require attention are valid, and we hope you will consider them.

Throughout our recommendations, we have tried to pay attention to three guiding principles that we believe are essential to the salability of a budget deficit reduction program.

First of all, the short-term burden of reducing the deficit should be widely shared across the society, across all elements of the population.

Second, we should maintain our national historic commitment to equity in the treatment of our people.

And finally, we feel that the deficit reduction program should be shaped so that it will have minimal adverse effects on savings and investment, given that higher levels of savings and investment are, the essential objective that we are seeking in reducing the deficit.

We feel that the success of the program also depends upon effectively controlling the growth of Federal spending. No deficit reduction approach can proceed from any other base.

We have endorsed and recommended to you the concept of spending caps, which is to say nominal dollar spending limitations that keep spending at a predetermined level despite underlying changes in the economy. We think that the 1987 budget summit agreement proved that spending caps can be a very effective tactic, and after considerable discussion, we felt that they represented the best approach on the spending side.

The spending caps which we have developed would result in budget savings of about $48 billion from the CBO baseline by fiscal year 1993. We are recommending an overall deficit reduction target of roughly $30 billion each year for the 4-fiscal years between fiscal 1990 and fiscal 1993 be achieved. The $48 billion reduction in spending limitation is ambitious, but we think it adheres to those three guiding principles which I mentioned to you.

After our review of the budget, the council concluded that we did not feel we could achieve credible deficit reduction simply by controlling spending, without undermining national security, breaking the Nation's longstanding commitment to equity or eroding our competitiveness in terms of further reducing the already low levels of savings and investment in the country.

Therefore, we concluded, perhaps reluctantly, that in addition to spending controls, there would have to be additional revenue raised to meet the $120 billion deficit reduction target that we had proposed.

We have suggested in our report what I will call a "menu" of possible revenue actions. In the aggregate, we estimate that all of the recommendations we have made would probably total something like $70 billion in additional revenues by fiscal year 1993. We feel that that level of additional revenue is more than is needed. Our calculation would be that approximately $48 billion by fiscal 1983 would be sufficient. We have in effect presented policymakers with a "cafeteria" approach of revenue items. It is, however, a package of revenue items which we feel in the aggregate is progressive in nature, and respects the three principles which, as I have said, guided all of our deliberations.

Finally let me just say, if it is not already clear, we certainly would not endorse any revenue increase whatsoever without spending caps and an ironclad commitment on the part of the public sector to restrain spending growth.

With those comments, I would respond to your questions, or if you would prefer to hear Mr. Duffey's testimony, we can proceed in that way.

Chairman SASSER. Thank you, Mr. Ong.

[The prepared statement of Mr. Ong follows:]

Council on Competitiveness

TESTIMONY OF JOHN D. ONG
CHAIRMAN OF THE B.F. GOODRICH COMPANY
EXECUTIVE COMMITTEE, COUNCIL OF COMPETITIVENESS

BEFORE THE SENATE BUDGET COMMITTEE
JANUARY 17, 1989
WASHINGTON, D.C.

Good morning. My name is John D. Ong. I am the Chairman of the B.F. Goodrich Company and a member of the Executive Committee of the Council on Competitiveness. I am pleased to have the opportunity to testify on behalf of the Council this morning on the Council's recently-released report, "Reclaiming the American Dream: Fiscal Policies for a Competitive Nation."

Mr. Chairman, Committee members, the volatility of financial and currency markets following the national election reflects the growing uncertainty about the future of U.S. economic policy. At the top of financial market concerns is apprehension that the new President and Congress may not be able to reach a consensus on a meaningful deficit reduction program.

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The Council, which is a non-partisan group of leaders from the business, labor and higher education communities, shares this concern. Although Council members have different backgrounds and responsibilities, we are united by a deep concern about the ability of this country to compete in a global economy, and we are committed to helping to ensure a rising living standard for all Americans. We believe that fiscal policy, specifically large federal budget deficits, presents the greatest obstacle to achieving these goals.

As the nation has learned over the past decade, large federal budget deficits have not led to economic or financial catastrophe. At the same time, however, deficits have and will continue to exact a stiff price on the nation's current and future living standards and on our ability to influence world economic and political affairs.

As a group singularly dedicated to improving American competitiveness, we are particularly concerned about the corrosive effects of deficits on saving and investment and their relation to productivity increases. Net national saving in the 1980s has averaged 3.0 percent of gross national product, well below the post war average of 7.0 percent, which many viewed as too low. Investment too has fallen -- from a postwar average of 7.0 percent of GNP to 4.8 percent in the 1980s. It is no coincidence that both national saving and domestic investment have hit post-war lows just when federal budget deficits have been at record highs. During the 1980s, federal budget deficits have averaged in excess of 4 percent of GNP.

We are similarly concerned about the nation's continued ability to reverse the trade imbalances that have come to characterize the trading system. Adjustments in our trade balance are inevitable. No nation, not even the United States, can finance its saving-investment gap through foreign capital or run trade deficits indefinitely. The challenge for policy makers is to facilitate the corrections while maintaining high growth levels and rising living standards.

The most effective means of reversing the deterioration in national saving and reducing the trade deficit is to significantly lower the federal budget deficit. There is a one-for-one relationship between deficit reduction and increased national saving.

There are a variety of ways to reduce the deficit and the Council program that I will outline for you is just one example of how it can be achieved. However, there are several issues that we believe must be kept in mind throughout the process of crafting a deficit reduction program.

First, a critical thesis underlying our report's conclusions and recommendations is that financing federal spending through running large deficits is more damaging to the economy than financing federal spending through higher taxes. The reason -- deficits directly reduce the pool of saving available for investment, whereas higher taxes reduce both consumption and investment. Given the overriding competitiveness goal of more saving and investment, it is clear why one is preferable to the other. The Council strongly believes that whatever level of federal spending the new Administration and Congress determine is appropriate to meet national needs, sufficient revenues should be generated to pay for that spending.

Second, we do not believe that strong economic growth alone -- even if we could predict it with some accuracy -- will be sufficient to eliminate the deficit. Recent history should be the best guide to disabusing us of this belief. In spite of the fact that the nation has experienced six years of strong, non-inflationary growth, federal budget deficits have not come close to disappearing. Nothing less than an all out effort to address the root causes of the structural budget deficit will complete the task.

Third, we must face up to the full extent of the problem. Despite the enactment of the Gramm-Rudman-Hollings legislation and last year's Budget Summit agreement, the federal budget deficit is increasing, not decreasing. The Congressional Budget Office estimates that the deficit will exceed $200 billion in the early 1990s and beyond. Only when the Social Security Trust Fund surpluses are included in deficit calculations does the deficit appear to be declining. Even these deficit projections are understated as they do not include the costs of the savings and loan bailout or the nuclear cleanup. We argue in our report that the Social Security Trust Fund surpluses should not be used to mask the true size of the deficit. This makes the challenge of deficit reduction even more formidable and the need for a credible, multi-year program even more immediate.

Fourth, U.S. success in bringing down the value of the dollar has opened up what we see as a unique window of opportunity for a successful transition to a pro-competitive fiscal policy without undermining overall economic demand. To capitalize on this window of opportunity, we strongly urge that the Congress and President-elect Bush take action on the deficit now. The prospect of continued improvements in the nation's trade deficit could offset the economic contraction associated with deficit reduction. Yet continued improvements in the nation's trade performance depend, in large measure, on success in reducing the deficit.

Finally, we do not believe that sequestration, which would be required under Gramm-Rudman-Hollings if deficit targets cannot be reached, is an appropriate solution to the problems at hand. Not only does it signal paralysis in our decision-making apparatus, it will undermine the nation's historic commitment to equity and adversely affect programs that are intricately related to the nation's competitiveness. As troublesome, it only postpones the type of tough decisions that are required to address the root causes of the deficit problem. We urge you and will likewise urge the President to make those tough choices sooner than later.

Over the past 15 months, as we have struggled to put together a fiscal policy to generate higher living standards, we have wrestled with these same issues. And we have emerged with some fairly straightforward ideas on how the deficit could be reduced, on how federal spending should be reprioritized and how the nation can address America's longstanding disinclination to save. We, too, faced tough choices in crafting this program. It was only our strong commitment to the goal of improving American competitiveness that enabled us to reach a consensus on the broad parameters of a pro-competitive fiscal policy. I would note that individual members of the Council's Executive Committee may not necessarily agree with each specific finding and recommendation.

The remainder of my remarks this morning will focus on the Council's short-term fiscal policy prescription to reverse the deterioration in the national saving rate.

The centerpiece of our short-term agenda is credible, multi-year deficit reduction. We believe that a minimally-adequate goal is to reduce the deficit by approximately $30 billion each year between FY 1990 and FY 1993, for combined deficit reductions of $120 billion. Such an effort, ambitious as it may seem, still will not eliminate the deficit altogether. As I noted at the outset, if Social Security Trust Fund surpluses are excluded from deficit calculations -- which we believe should be done -- the budget deficit is projected to be more than $200 billion in each of the next several years. $120 billion represents a major down-payment on deficit reduction, and will do much to boost national savings, but budget stringency will be needed beyond FY 1993.

Our objective was clear from the start -- to develop a program of deficit reduction to meet our target. However, in considering the specifics of spending restraints and revenue increases, we adhered to three principles. The principles we adopted facilitated our consensus-building effort, and we believe that if they are also adhered to in the making of budget policy, they could enhance the political salability of the deficit-reduction program you will put together.

The first principle was that the burden of deficit reduction must be widely shared. We have all contributed to the problem, now we must all join together to solve it.

Second, we believe that in reducing the deficit, the nation's historic commitment to equity must be preserved. The budget cannot be balanced on the backs of the needy.

Finally, we believe that deficit-reduction measures should avoid to the extent possible any adverse effects on private saving and investment. This is consistent with our overall goal of improved capital formation and investment.

Mr. Chairman and Members of the Committee, we believe that one of the principal conditions for reducing the deficit is to control the growth in federal spending. To accomplish this objective, we recommend that all public programs, except for those that benefit the truly needy, be reviewed for possible budget savings, and that includes politically-sensitive entitlement programs. It stretches our plausibility to believe that the deficit could be reduced by $30 billion annually by exempting almost half of the budget, which is just about what entitlement spending now comprises.

However, even if all programs are on the table, the problem of enforcing spending reductions remains. To assure that programs are not added that raise spending, the Council supports the adoption by the Congress of annual spending caps. The premise underlying spending caps is simple: Congress and the President agree on a certain level of overall spending for a portion of the budget, and adhere to that amount on a multi-year basis. The composition of spending can change, but the total amount cannot. Using spending caps means that Congress can set priorities within a pre-set level of taxpayer resources, but it must also stick to the objective of controlling spending growth by not spending more than the cap allows. The 1987 Budget Summit showed how effective spending caps could be.

As you know, Mr. Chairman, spending caps represent a somewhat different approach to controlling spending growth. An agreement to reduce the budget deficit by a certain amount of dollars might not even reduce the deficit if the underlying baseline assumptions change, as they always do. We propose that Congress set the level of spending by caps and stick to that spending path. Of course, to reduce the deficit, caps would have to be established at a level lower than the latest baseline.

Our report proposes caps for the three major budget categories: national defense, entitlements and mandatory spending, and non-defense discretionary. By FY 1993, our caps would yield $48 billion in savings from projected spending levels. Interest savings associated with deficit reduction would yield further outlay reductions. Of the $48 billion, $13 billion would come from defense, $26 billion from entitlements and $9 billion from non-defense discretionary. This represents a proportional decrease from the FY 1993 CBO baseline estimate for each spending category of about 3.7 percent. That's not a magic number, but it is within reach and it would get you about halfway to the $120 billion goal.

Our report is filled with specific recommendations for each area of the budget, so I won't go into great detail here today. Suffice it to say that the Council could not achieve a desired level of savings on the outlay side of the ledger without including programs like Social Security, Medicare, farm programs, many non-defense discretionary programs and defense. As I mentioned, we believe all programs should be on the table if we are going to get a real handle on spending growth.

However, as you will see from the report, we were able to achieve these savings while holding true to our principles. We have tried to limit any adverse effect on the nation's neediest citizens and to avoid compromising vital income and health support to the elderly. We believe that modest restraints can be placed on programs in defense, entitlements and discretionary programs without compromising the integrity of those programs.

Mr. Chairman, we began our effort to craft a deficit reduction program with an open mind. We did not anticipate spending cuts of a pre-determined magnitude or tax increases of a certain level. However, we did want to explore all major reduction options on the spending side of the ledger before even considering new revenues. But even with our ambitious agenda, we determined, after long and hard analysis, that reducing the deficit on the spending side of the ledger alone would exact too stiff a price. We believed it could undermine national security, break the nation's longstanding commitment to equity or erode America's competitiveness. In making this determination, we have relied upon the CBO's assumptions about interest rates, employment and economic growth.

Some will differ with our assessment and will present alternative plans. However, if a formula for deficit reduction through spending restraint remains as elusive to the new Administration and Congress as it has to us, then we expect that all parties will consider revenue increases.

As a group concerned about capital formation and investment, we agreed it was important to pay for federal spending through revenues rather than borrowing. To restate a point made earlier -- and a point that we think is critically important to the whole debate on deficit reduction -- we believe that tax finance is preferable to deficit finance. Moreover, the prospect of revenues will do much to sharpen the focus of the spending debate. As long as both the public and policy makers believe we can have spending without paying for it directly, the ability to control the growth in federal spending becomes that much more limited.

We recommend that the same three principles we adhered to in establishing spending restraints also guide any possible revenue increases. To reiterate: the short-term sacrifice should be widely shared; equity should be preserved by assuring that revenue increases are as progressive as possible; and adverse effects on private saving and investment should be minimized.

The Council's report includes a specific menu of revenue options that satisfy in whole or in part these criteria. It is a broad menu, which if taken together could raise an estimated $70 billion in FY 1993. Of this, we conclude that approximately $48 billion in revenues would be required to meet our target of $120 billion in deficit reduction by FY 1993. Again, I'll not get into the nitty-gritty here, leaving that to the report.

Let me state unequivocally that the Council would not endorse revenue increases of any kind without spending caps and an iron-clad commitment to restrain spending growth. As I stated at the outset, the success of deficit reduction depends upon controlling spending.

Mr. Chairman, my remarks this morning have focused heavily on reduction of the federal budget deficit. This is not to suggest that the Council believes deficit reduction is in and of itself sufficient to ensure a pro-competitive fiscal policy. A longer-term agenda must complement the effort to improve the saving rate through deficit reduction. I would like now to turn to Chancellor Duffey to outline the longer-term program we have developed to assure fiscal policy promotes our nation's competitiveness.

Thank you very much for your time today and for your interest.

Chairman **Sasser**. We will proceed with Dr. Duffey's testimony and then turn to our panel here for questions for both of you.

Dr. Duffey.

STATEMENT OF DR. JOSEPH DUFFY, CHANCELLOR, UNIVERSITY OF MASSACHUSETTS, AND EXECUTIVE COMMITTEE MEMBER, COUNCIL ON COMPETITIVENESS

Dr. **Duffey**. Thank you, Mr. Chairman.

I appreciate this opportunity to represent my colleagues and discuss this report with you, which is the result of 15 months of study and deliberation.

With your permission, I ask that my prepared statement be entered into the record, and I would like to comment briefly upon that statement, note some sections of the testimony and then respond to questions which members of the committee may have.

It goes without saying, Mr. Chairman, that what you have before you is not a startlingly original document. These are observations and recommendations for which we cannot claim a copyright or great originality. You have heard them before. But I will note that these observations and recommendations are gathered here in a complex of ideas and set in a context of conviction and a point of view that may give them something of a unique character.

That conviction and that point of view is really what we are urging for your consideration. The rest will follow.

Before I describe that commitment and perspective, however, let me reinforce what John Ong has said about the membership of the Council on Competitiveness, and particularly this group, which began 15 months ago to study and debate these questions.

It is significant, I think, that we represent business, labor and education, and that we engaged in sustained exchange in the preparation of this report.[1] We all began with different responsibilities and interests. Many of us changed our minds in the process of looking at the problems and seeking consensus. We exchanged views and perspectives in long discussions, and we tried to fashion a set of comments and recommendations which would represent what we take now to be the obligatory actions which follow from our mutual concerns and our sense of civic necessity at this time in America.

We began with a fundamental concern for the return to solvency of the American economy. Like most Americans today, we appreciate the achievements of the past decade: lower inflation; modest but evident economic growth and expansion; a substantial decline in unemployment; rising incomes.

One of the lessons we have learned in the last decade is that unlike the period in which many of us came to maturity, this is not a time in which American business, the health of the American economy, its viability can be taken for granted. There will perhaps never be another time like that in our history.

Like many Americans, we see some warning signs. We see a significant number of Americans, young Americans especially, have been left out of the economic prosperity. We see instability in world markets. We see a continuing trade deficit. We see an educational system that clearly is flawed. Our colleges and universities are the envy of the world, I think to a large extent because of the pluralism of our higher education system, the openness of that system, and its accessibility to our people.

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[1] See p. 66.

But by almost every measure, our elementary and secondary education systems are falling behind, and that is not a good omen for the future.

We see a Federal debt which has grown beyond even the most pessimistic assessments of a decade ago. At first glance, our report seems to be addressing the question of the Federal deficit. But our problem is not with the fact of the deficit itself so much as with the circumstances that have created that deficit and the fact that the deficit has begun now to spawn new problems for the economy and the society as a whole, as well as to exacerbate existing problems.

The situation is this. Our excessive national borrowing has not been for the purpose of investment for the future, a perfectly valid reason for borrowing. It has been for the purpose of meeting current expenses. We have been borrowing for current consumption. That means we have not been paying our way or facing reality. We have been living in a world of evasion and illusion.

Now, Mr. Chairman, we put before you and the members of your committee in this report what first must seem to you a perplexing Council, a kind of a paradox, because on one hand, we take very seriously the need to reverse the trend toward ever greater public borrowing. We must begin now, we must begin this year, to pay down our debt. We have to undertake this course with a clear path and a steady resolve over the next half-decade. We must, by clarity of will and purpose, set ourselves a course toward closing the gap between income and expenditures in the Federal budget.

We need—and soon—to send a clear message to reassure nervous world markets that we mean to live within our means. This may or may not mean new taxes, but it surely means new revenues. And it will require great care to avoid the kind of lurching action or passive inaction which might precipitate a deep recession, not only here but around the world.

A recession would compound our plight 100-fold. If we have a recession, then our report should be set aside, because all bets are off.

We propose tackling the fiscal deficit, and yet, Mr. Chairman, we come to say that we have accumulated other deficits at first appearing less tangible, but surely real, deficits which we have accumulated and which each day accumulate with a cost of another kind—deficits of neglect—neglect of the resources which nurture scientific innovation and manufacturing productivity; neglect of an aging infrastructure; neglect of the at-risk children who will in not much more than a decade now be one-quarter of our work force.

This is why we offer you a perspective. We bring together what appear to be almost contrary recommendations. We must begin to attack the deficit and we must also make investments for the future. At the same time, we ask for increased Federal spending in some areas of economic and social investment, while we begin the mandatory task of tackling the deficit.

What we seek, then, is a reorientation of thought and of fiscal strategy. We have concluded that there is no choice but to seek to manage our way back to fiscal and social solvency through the exercise of will, of choice, of restraint and investment. That is the conviction we urge upon you.

This paradox is partially resolved through bringing together two goals: higher levels of national savings and greater investment in the future. In our report, we suggest three policy actions. There should be a shift of Federal budget priorities toward investments in productivity-enhancing activities. That is the first goal. Second, measures should be taken to ensure the integrity of the Social Security Trust Fund so that the trust fund surplus can be used for its intended purpose—to finance the retirement of the baby boom generation. And finally, we recommend consideration be given to how private savings can be increased, including revisions in the Tax Code.

My statement focuses primarily on the first element of this longer-term agenda, but summarizes briefly the report's recommendation with respect to the others.

The first shift in priorities is in the direction of what we call the foundation of economic competitiveness: Our resources for scientific and technological innovation, our public transportation and productive infrastructure, and the Nation's work force.

The reason for the council's endorsement of higher funding levels for these programs despite the imperative of budget reduction is simple: Sound public investment strategies in these areas are the key to spurring U.S. productivity growth. If the Nation does not address in a forthright way the need to enhance our human and technological resources and the underlying problems of infrastructure, the sluggish productivity which has characterized our performance over the last two decades is likely to continue, and the cost of low productivity is devastating to the Nation's living standards.

Had productivity rates since the early seventies equalled those of the fifties and sixties, our Nation would be about $2 trillion wealthier today. That adds up to more than $8,000 for every man, woman and child in America.

During previous decades, we were able to achieve strong economic growth without major increases in productivity. The growth of the economy was driven in large part by the entrance of new workers into the labor force. Because more and more people were working and producing, the individual worker did not necessarily have to be enormously productive.

Today, we can no longer achieve significant or even modest economic growth without more rapid productivity expansion. Looking just ahead we see the problem of the labor force projected to grow by about 1 percent a year over the next decade compared with a 3 percent per year growth in the seventies and early eighties. Because of our poor productivity performance, our industrial competitors have nearly closed the gap that once separated U.S. and foreign producers. In some industries, in fact, they have taken the lead, eliminating the traditional unit labor cost advantage we once held.

Productivity expansion is not simply an economic abstraction. It is essential to the achievement of other social and economic goals such as care for the elderly. In the 1950s, 17 active workers supported each retiree. By the 1990s, we will have only three workers for each retiree. I think the significance of increases in productivity on the basis of that comparison speaks for itself.

But this is not simply a matter of increasing the physical capital which workers have at their disposal. That is a necessary condition. It is the reason we place great emphasis on deficit reduction. It is not a sufficient condition. And that is why in this report, we address the questions of a skilled work force, able to adapt to new technologies. When we had a production based primarily on the assembly line, work was simple and routine; more capital for each worker meant higher individual productivity. Today, the assembly line is fast disappearing, and the nature of work is changing just as quickly, so today's workers must be able to analyze and solve problems, to manipulate abstract symbols rather than hand tools, and to read and understand technical literature. Workers are more likely to work with robots and computers than with hammers and screwdrivers. So productivity growth cannot be achieved simply by generating additional capital investment. Greater public investment in technology infrastructure and education is also required.

In terms of resources for technology and innovation, we call attention to the need for greater civilian investment in R&D. Here, the Federal Government plays a major role as an investor and a catalyst, a role that has not been taken up by the States and is not likely to be taken up even as the allocation of resources and expenditures has shifted to a significant measure back to the States.

The Federal budget which will be considered by the Congress this year represents a very major part of the allocation of our Nations resources. Our perspective here was summarized well by the conclusion which Herbert Stein wrote a week ago in an article in the Wall Street Journal. He wrote as follows: "The issue is not whether we should balance the budget. It is how high national savings should be. The issue is not how high taxes should be. It is how much of the national output we should be consuming. The issue is now whether to allow medical benefits to be excluded from taxable income. The issue is whether we want to continue to increase the share of national output going to medical care."

Addressing the question of investments in the infrastructure, I have called attention in my testimony, as we have in the report, to the critical problem of developing science and engineering faculty. The National Science Foundation has supported programs in this area. There are 1,300 vacant graduate engineering faculty positions in U.S. universities today. More and more assistant professorships are being filled by foreign-born engineers, simply because there is not an adequate supply of American engineers.

Problems in faculty development, however, are even more troublesome at the elementary and secondary level. There, 200,000 teaching jobs will have to be filled in the next decade because of retirements, in a situation in which more than 60,000 science and math teachers are already underqualified to teach their subjects.

We describe the problem of an aging infrastructure in our report, and finally, we discuss the problem of individuals, and most especially the problem of children. We face considerable challenge across the spectrum of education and training, but the problems faced by disadvantaged children are the most desperate. Nearly one-quarter of our children now live in poverty, and their personal circumstances often make development and learning extraordinarily difficult. These children represent a growing portion of the work force of the next generation. They must be well-educated and well-equipped for the types of jobs the economy will produce. If current practices persist, many will enter the work force possessing few of the skills needed to obtain anything but a dead-end job.

The Federal Government cannot solve this problem alone. But the Federal Government can have the most immediate and dramatic impact on the problems in the educational system by attending to the urgent needs of disadvantaged children.

We recommend that the Federal Government increase funding for childhood nutrition, for Head Start—a proven program—for Chapter I of the Education Consolidation and Improvement Act. Some funding increases should begin immediately, with additional resources provided throughout the decade to ensure that eligible populations are adequately cared for. Investments in such programs will help ensure that disadvantaged children receive the assistance they need and deserve from early childhood through high school.

Let me in conclusion highlight the two additional components of the council's longer-term fiscal agenda. The first is the recommendation that the Social Security Trust Fund surpluses be used for their intended purposes, to pre-fund the retirement of the baby boom generation. That was the rationale behind the payroll tax which was adopted in 1984. By masking the size of the Federal deficit through the use of these trust fund surpluses, we are in essence undermining efforts to ensure that policymakers will not face even less attractive options in the year 2010 than we face today—more dramatic tax increases and drastic spending cuts, or even larger deficits.

The second component is a recommended examination of how the Nation can facilitate private savings. The problem of a low national savings rate is not a new one. We have talked in some detail about this in our report. We need to explore mechanisms, including changes in the Tax Code, that can begin to reorient American thinking away from consumption toward increased savings and investment. This is largely unexplored territory but is one that is rich with possibilities and benefits.

This is a brief sketch of the proposals we have put forth. We pledge to you whatever help and encouragement and support we can muster as you undertake this important and awesome responsibility of allocating a major share of our national production.

We know you share our concern for a strong, confident, and just society and economy. In sum, we ask you to bring together these two goals—to reverse the trend toward excessive Government borrowing and to begin a concerted program of investment for the future.

If I remember correctly, the essayist E.B. White once said: "Every morning, I wake up with two desires—to enjoy the world and to change the world." And then he said, "That sometimes makes it hard to plan the day."

We have set before you two goals which we do not pretend make it easy to plan for the future. But we believe that both objectives are worth the effort: to begin a return to fiscal solvency and to begin a concerted effort to invest in and for the future.

Thank you.

Chairman Sasser. Well, thank you, Dr. Duffey, for your very interesting testimony.

[The prepared statement of Dr. Duffey follows:]

Council on Competitiveness

STATEMENT BY JOSEPH DUFFEY
CHANCELLOR, UNIVERSITY OF MASSACHUSETTS
EXECUTIVE COMMITTEE MEMBER, COUNCIL ON COMPETITIVENESS

SENATE BUDGET COMMITTEE
JANUARY 17, 1989
WASHINGTON, D.C.

Good morning. My name is Joseph Duffey. I am the Chancellor of the University of Massachusetts and a member of the Executive Committee of the Council on Competitiveness. I am pleased to have an opportunity to testify this morning on behalf of the Council.

Mr. Chairman, the challenge to develop fiscal policies that improve America's competitiveness is not limited to deficit reduction, although this is a necessary first step. We believe that there must also be a fundamental restructuring of American thinking -- both public and private -- toward higher levels of saving and investment. We believe that three sets of policy action are required. First, there should be a reshifting of federal budget priorities toward investments in productivity-enhancing activities. Second, measures should be taken to ensure the integrity of the Social Security Trust Fund so that the Trust Fund surplus can be used for its intended purpose -- to finance the retirement of the baby boom generation. Finally, we recommend that consideration be given to how private saving can be increased, including revisions in the tax code.

This morning, I would like to focus my remarks on the first element of the longer-term agenda -- shifting budget priorities so that public spending better supports what we refer to as the "building blocks of competitiveness" -- the nation's work force, our scientific and technological foundation and the public infrastructure.

The reason for the Council endorsement of higher funding levels for these program, despite the deficit reduction imperative, is simple -- sound public investment strategies in these areas are key to spurring U.S. productivity growth. If the nation does not address head on the need to enhance our human and technological resources and our underlying infrastructure, the sluggish productivity performance the United States has turned in for nearly two decades is likely to continue. The cost of low productivity is devastating to the nation's living standards. Had productivity growth rates since the early seventies equalled those of the 1950s and 1960s, our nation today would be about $2 trillion wealthier.

That adds up to more than $8000 for every man, woman and child in America.

During previous decades, the nation has been able to achieve strong economic growth without major increases in productivity. The growth of the economy has been driven in large part by the entrance of new workers to the labor force; because more an more people were working and producing, an individual worker did not necessarily have to be enormously productive. Today, we can no longer enjoy the luxury of growth without more rapid productivity expansion. The labor force is projected to grow only about one percent per year in the next decade, compared with three percent per year in the 1970s and early 1980s. Moreover, because of our poor productivity performance, our industrial competitors have nearly closed the productivity gap that once separated U.S. and foreign producers -- in some industries they have taken the lead -- eliminating the traditional unit labor cost advantage we once held.

Productivity expansion is not simply an economic abstraction. It is essential to the achievement of other social and economic goals, such as care for the elderly. In the 1950s, 17 active workers supported each retiree. By the 1990s, we will have only 3 workers for each retiree. That means that fewer active workers will be paying the payroll taxes needed to fund the retirement and health benefits of each retiree. In other words, each worker will have to pay much more than his or her counterpart in the 1950s. So unless those workers are more productive, generating enough income to provide themselves with a good income while helping to finance the health and retirement needs of the elderly, the nation could face the choice of supporting the elderly or maintaining the take-home pay of workers. Without substantial individual productivity gains, the economic pie may not be large enough to do both.

Expanding productivity in today's economy is not simply a function of increasing the physical capital workers have at their disposal. That is a necessary condition, and the reason we place such great emphasis on deficit reduction, but it is not a sufficient condition. Productivity today depends as much on a skilled workforce and the rapid adaptation of new technologies as on new plant and equipment.

In the era of the assembly line, work was simple and routine. More capital for each worker meant higher individual productivity. However, the assembly line is fast disappearing and the nature of work is changing just as quickly. Today's workers need to be able to analyze and solve problems, manipulate abstract symbols rather than hand tools, and read and understand technical literature. Workers are more likely to work with robots and computers than hammers and screwdrivers. So productivity growth cannot be achieved simply by generating additional capital investment. A broader public investment program in technology, infrastructure and education is required.

The call for technological support may sound unusual. America, after all, enjoys a rich and long tradition of technological preeminence. Indeed, technology is our nation's wellspring of economic growth and vitality. However, our technological leadership is now being stiffly challenged. More and more countries have recognized the strategic value of technology and systematically cultivated it, often by well-conceived public investment strategies. Their hard work has paid off in the marketplace.

In 1986, our nation experienced its first high-tech trade deficit. Japan has seized the lead in the development of emerging technologies such as high-definition television.

Europe is playing the technology-development game, too. The Common Market countries have initiated numerous technology programs with names such as BRITE, COMETT and ESPRIT.

In the meantime, the United States has seen the federal government reduce its role in technological development. Civilian R&D, measured in constant dollars, is lower today than it was in 1980. Funding for university research facilities has fallen by 95 percent in real terms over the past two decades.

However, the story is not all bad news. On the contrary, in pursuing new technology opportunities, the US brings many strengths. Our nation has a tradition and foundation of scientific expertise, a university system that remains the world's envy, a legacy of entrepeneurship and a flexible form of government able to respond to new opportunities and changing circumstances.

If we are to sustain our technological leadership and maintain our economic competitiveness, we must build on these strengths, and the federal government has a critical role to play. To restore the federal presence and boost our nation's technological development programs, the Council recommends immediate funding increases for the National Science Foundation, with the objective of doubling its budget in five years.

Several areas deserve special attention. For example, NSF provides funds for science and engineering faculty development. There are currently an estimated 1300 vacant graduate engineering faculty positions at US universities.

More and more assistant professorships are being filled by foreign-born engineers, simply because there is not an adequate supply of American engineers. Problems in faculty development are truly troublesome at the elementary and secondary level, where some 200,000 teaching jobs will have to be filled in the next decade because of retirement. However, some 60,000 science and math teachers are already underqualified to teach their subjects.

The Council also supports a major infusion of federal funding for university infrastructure, which has not kept pace with research needs. We support legislation that calls for $5 billion in additional funding over the next ten years.

The second component of our three-part investment strategy is infrastructure. A well-functioning transportation infrastructure is very important to economic competitiveness. The problems in this area are well-known. Roads and bridges across the country are in dire need of repair. A recent government report rates 60 percent of all urban principal roads as being in fair or poor condition. More than 40 percent of the nation's 576,000 bridges are either structurally deficient of functionally obsolete.

The federal government currently levies taxes on motor fuels to help finance infrastructure construction and maintenance. The trust funds collecting these revenues are being used for deficit reduction, and not for their intended purposes. Clearly, if the nation is to have a well-functioning transportation system, which is essential for economic efficiency, a greater portion of these revenues must be used for infrastructure development. We recommend that the Trust Fund monies already accumulating be invested in the infrastructure and that a substantial portion of any gasoline tax increase also be used for highway development and repair.

Technological advancement and infrastructure improvement are essential to improving our nation's economic competitiveness, but in the final analysis, the effectiveness of investments in these areas depends on fundamental improvements in the nation's human resources. Without knowledgeable, highly-skilled workers able to adapt to rapidly-changing economic circumstances, other efforts to improve productivity and overall competitiveness will inevitably fall short of their potential. All economic activities, from developing leading-edge technologies to managing old-line manufacturing plants, depend on skilled, motivated and flexible workers.

Our nation faces considerable challenges across the spectrum of the education and training system, but the problems faced by disadvantaged children are the most desperate. Nearly a quarter of our children live in poverty. Their personal circumstances often make development and learning extraordinarily difficult. These children represent a growing portion of the work force of the next generation, so they must be well-educated and well-equipped for the types of jobs the economy will produce. Yet if current practices persist, many will enter the work force possessing few of the skills needed to obtain anything but a dead-end job. The federal government can have the most immediate and dramatic impact of the problems in the education system by attending to the needs of disadvantaged children.

The Council recommends that the federal government do its part by increasing its funding for childhood nutrition, for Head Start, and for Chapter I of the Educational Consolidation and Improvement Act. Some funding increases should begin immediately, with additional resources provided throughout the decade to ensure that eligible populations are fully served. Investments in all areas will ensure that disadvantaged children receive the attention they need from early childhood through high school.

Once people enter the work force, they will need training and retraining to adapt to constantly-changing technologies and markets. Already, the training needs of the work force outstrip the availability of services. One of the principal shortfalls shows up in the training of dislocated workers. Many workers separated from their jobs possess few transferable skills, yet have neither the time nor the resources to equip themselves for jobs that allow them to earn a good wage and achieve their productive potential.

The Council recommends that funding for the dislocated worker training program authorized by the 1987 trade bill be provided.

I would now like to briefly highlight for you the two additional components of the Council's longer-term fiscal policy agenda.

The first component is a recommendation that the Social Security Trust Fund surpluses be used for their intended purpose -- to pre-fund the retirement of the baby-boom generation. The rationale behind the large payroll tax increase in 1984, which has generated the Trust Fund surpluses we see today, was to avert a financing crisis in the early 21st century when the first wave of baby boomers started to retire. By masking the size of the deficit through the use of the Trust Fund surpluses, we are in essence undermining the effort to prevent policy makers from facing even less attractive options in 2010 than we face today: dramatic tax increases, drastic spending cuts or even larger deficits.

The second component is a recommended examination of how the nation can facilitate private saving. America's problem of low national saving is not a new one. We need to explore mechanisms -- including tax code changes -- that could reorient American thinking away from consumption and toward increased saving and investment. This is largely unexplored territory -- one that is rich with possibilities.

In sum, the Council's report recognizes that America's economic competitiveness depends on fundamental changes in fiscal policy. The first step is deficit reduction. But deficit reduction must be complemented by a longer-term public strategy to expand the nations' commitment to saving and investment, with special attention to investments in people, research and development and the economic infrastructure.

Thank you.

Chairman SASSER. We have been joined by our colleague, Senator Sanford. We want to welcome you this morning, Senator Sanford. We are pleased to see you looking so well after this long recess.

Mr. Ong, I was fascinated by something you said during your direct statement. You were indicating that we ought to go the way of reducing the deficit by looking at revenues, if I understood you correctly, a mix of revenues and spending reductions. But you also recognized the fact that if we went the revenue route or the partial revenue route, this would have the effect of reducing consumption to some extent.

And the general thrust of your statement and that of Dr. Duffey seemed to be that we should go the route of reducing consumption and moving in the direction of savings and investment. And, looking down the list of those who make up the membership of your council, I am not accustomed to a chief executive officer of Goodrich, or the chief executive officer of Ford Motor Company, or this list of blue ribbon manufacturers here in the United States taking the view that perhaps we ought to put some reduction in the consumption equation and look more in the direction of savings and investment.

I have always thought of manufacturers, particularly those who manufacture automobile components or automobiles as saying: "Consume now, buy now, pay later." I would just be interested in how the Council came to this conclusion, given the make-up of the committee, and what your personal views are on the question of consumption vis-a-vis savings and investment for the future.

Mr. ONG. Well, let me say, first of all, Mr. Chairman, that the members of the Council agreed to serve in that group, and many of us were alumni of the Young Commission of some years ago, because we had a conviction that America's competitiveness is eroding, and that there are a number of things that need to be done not only in the public sector, I would say, but in the private sector as well, to try to stem that and to get us back on a course of greater productivity improvement and rising standards of living.

Those of us who joined the council went in with the idea that we wanted to come up with solutions to problems, so we approached it from a problem-solving rather than an ideological point of view. We came, as you have observed, from many different backgrounds, with different constituencies, and traditionally different ways of looking at problems particularly on revenues.

But once we were imbued with the realities of the situation as I tried to point them out in my testimony, it was relatively easy to come to some consensus.

Now, to address the issue of revenue specifically, we really look at that in both a near-term view as part of the solution to the deficit reduction problem and also, as Joe Duffey has pointed out, from a longer-range point of view. Let me speak about those separately.

As I said a while ago, after looking at what we view as the realities of the budget situation, we came to the conclusion that we could not see a credible way, a way that we felt was politically credible, to reduce the budget simply by reduction or control in the rate of spending growth. So we, perhaps reluctantly, reached the conclusion that to address the deficit in a meaningful manner, Congress and the Administration were going, eventually, to look at revenue enhancement.

In coming up with some recommendations on additional revenues we looked at the current tax system. None of our recommendations have anything to do with forms of taxation that are not already on the books. And we feel that, as I said, in the aggregate, the recommendations we have made are progressive and honor the national commitment to equity.

Looking down the road longer-teem, we very much feel that some attention should be given to methods of stimulating private savings and investment. And in doing that, obviously, the tax system of the country is a major item to be addressed. Our conviction is that our tax system is at the moment and has been for many years essentially an anti-savings, anti-investment, pro-consumption tax system, and we think that a fundamental change has to be made in that.

There are a variety of ways in which that could be approached. Some of those ways have been explored in the past. Others, I think, even in the public policy arena, are still quite novel and unexplored. And we are simply urging the Executive Branch and the Congress to begin the task of looking at the whole fiscal system of the country with a view to giving it a more pro-investment, pro-savings bias than it apparently has.

Chairman SASSER. Well, I must say, Mr. Ong, I find it in the finest tradition of American business that chief executive officers of great American corporations appear to me to be willing to, if necessary, sacrifice a point or two off short-term net sales in the long-term national interest. That is a most refreshing viewpoint, and frankly, I thank you for it.

Now, let me just ask you both this question. There are some who argue today that it is reasonable to believe that a cap on spending combined with economic growth will reduce the deficit to manageable levels in the outyears. Now, my question is this. Whether one excludes the surplus that is building up in the Social Security Trust Fund or whether one includes the Social Security Trust Fund in the calculations, does the Council believe that spending restraint and economic growth alone can bring the deficit down to manageable levels and permit room for the crucial infrastructure investments that have been discussed here today by both of you?

Mr. ONG. Let me begin, and I certainly urge Joe to contribute his thoughts. We do not see a way to do that. Obviously, we have no exclusive wisdom in this regard. It could be that there is a way to do that, but after more than a year of careful study, considerable discussion, examination with experts in various areas of public spending, we do not see a way in which, a combination of spending controls, coupled with continued economic growth is going to make a meaningful reduction in the budget deficit. That conclusion, of course, is much more pronounced if you do not, as we would urge, include the Social Security Trust Fund in that deficit calculation. Perhaps there is one there that we have not been clever enough to discover. But we do not believe that.

Chairman SASSER. Well, I think the statistics seem to bear you out. Would you like to comment on this, Dr. Duffey?

Dr. **Duffey**. Well, I think we all wish it could be the case, but the key to growth is the opening of new markets. To go back to your earlier question, one of the reasons for the perspective of the businessmen who sat around the table is that they are all engaged in an economy that they now understand is so interdependent with other parts of the world that they have got to be more competitive. So they seek more openness in the market, more investment, and greater productivity.

It would appear as though the deficit is hindering our ability to accumulate and move the capital in productive directions.

Chairman **Sasser**. Well, let me ask you this question. If we continue down the course of minimal or no real deficit reduction, holding out the hope that growth and restraint alone will solve the problem, what does the economic future look like for the United States?

Mr. **Ong**. Well, I do not think we want to put ourselves in the position of forecasting the economy, something which I have never been successful in doing——

Chairman **Sasser**. Well, neither have most economists, Mr. Ong, so you would be in good company.

Mr. **Ong**. But it seems to us axiomatic that if nothing is done to solve this problem, then the negative influences that derive from it—the continued erosion in the savings rate, the consequent under-reinvestment in our economy—and I say that in the broadest sense, not just bricks and mortar and machinery, but also in the vital human resources which Joe Duffey has mentioned and which are critical to our continued long-term economic competitiveness—that will continue, and as a result of that, our productivity growth will continue to be "stalled."

So, a situation which is already serious and which is ameliorated primarily by the tremendous vigor of the economy, the length of the growth cycle that we are now in, will become more serious still.

Chairman **Sasser**. Do you wish to amplify on that, Dr. Duffey?

Dr. **Duffey**. No. I will let that stand. Thank you.

Chairman **Sasser**. I have some more questions, but we are trying to hold the first round to 5 minutes, and I suspect I have exceeded my 5 minutes.

Senator Gramm.

Senator **Gramm**. Mr. Chairman, let me begin by thanking these gentlemen for being here and for their work. I would like to make a couple of observations, and then I would like to pose a couple of questions.

First of all, Mr. Chairman, I cannot help but note that I do not see anybody on this Council on Competitiveness from Mabank or Muleshoe or Cut and Shoot, or all the little towns and villages that make up my State.

Second while we certainly have a distinguished group of citizens here, my guess is their income is roughly equal to ten times that of the national average. And Mr. Chairman, I think that is reflected in the recommendations that are made here.

I would like to begin by trying to set your proposals in an aggregate framework. First of all, for your proposed recommendations—changes to achieve the results that we are committed to—a balanced budget by 1993—we are assuming an economy that is generating about a 3 percent growth rate. That means that revenues will grow by about $80 billion a year due to economic growth. That is $320 billion of revenues by 1993 coming from economic growth. You propose $72 billion in taxes. So that means new revenues of roughly $392 billion, which is an average growth in revenues coming into the Federal Treasury of roughly 8 percent.

Your recommendations of spending constraints, when they are added up, actually work out to allowing Federal spending to grow by 6 percent a year. Federal spending would grow by $272 billion over this period. I would like to know where the equity is.

Where is the equity in revenues growing by 8 percent and spending growing by 6 percent? Where is the spending restraint? Where is the equity to the people who are pulling the wagon in which an ever-increasing number of people are riding?

May I begin, Mr. Ong, with you?

Mr. ONG. Yes, Senator.

First, I would say that there are a number of Texans within the membership of the Council on Competitiveness. Admiral Bobby Inman, one of them, is a member of our executive committee, who was involved in this report.

Second, let me just make one correction of fact. While we did in our report lay out a series of revenue options which we estimate could result by 1993 in about $70 billion of additional revenue, we also, as I have mentioned earlier, feel that approximately $48 billion would be required by fiscal year 1993 to meet our deficit target.

As I also pointed out, we do not want to dwell too much on——

Senator GRAMM. If I might interrupt you, my numbers are based on $48 billion in new revenue—well, on $48 billion in taxes, you are talking about.

Mr. ONG. All right, good. I thought you had said $70 billion.

In any event, our idea was to elicit your interest in a variety of possible approaches both on the spending side as well as the revenue side, and we would not put too much importance on any specific recommendations. There are a variety of things that could be done. There are a variety of places in which revenue could be enhanced or spending reduced or the growth of spending contracted.

We think the important thing is to address the overall issues.

To the question of equity, though, which you raised, we feel that if the recommendations, broadly speaking, that we have made are honored, they would represent a substantial reduction on the spending side. And you are quite right, a lot of that can perhaps more properly be termed contraction in the growth of spending as opposed to actual reduction in spending. But when so much of the Federal budget is in effect indexed in one way or another, it seems to us that limiting or controlling growth is in effect a reduction in spending, because those increases——

Senator GRAMM. Well, if I might inject, since I see my warning light is coming on here, I guess the point I am making is that your program, when you break it out in aggregates, is limiting Federal spending growth to an average annual rate of 6 percent. Very few working families in America have a similar constraint. Most of them have a much smaller constraint. So I do not see the fiscal constraint.

Also, as I look at your list of taxes, and here, reference to this shared sacrifice, I see the standard "sin taxes" which are highly regressive, whatever one thinks of smoking and drinking. I see a motor fuel tax of 20 cents a gallon, which would be devastating to working people living in rural areas in the western part of the country. I see the standard old chestnut of are we going to have an IRS agent in every household to collect taxes. I see a tax on home equity loans.

I do not see a single corporate tax in here. Why is that?

Mr. Ong. Actually, our recommendations would involve about $5 billion in additional corporate taxes. This was a figure that we arrived at taking into account the rather substantial increase in corporate taxes that resulted from the 1986 Tax Reform Act.

Again, our recommendation is to try and achieve some balance in terms of where the sacrifice would fall. In terms of the excise tax recommendations we have made, it is true that taxes on alcohol or tobacco, for example, are theoretically regressive in nature. On the other hand, those items of consumption are obviously discretionary ones; they are not necessary for life. And indeed, if you look at the——

Senator Gramm. You certainly could not say that about gasoline.

Mr. Ong. Let me address gasoline separately, if I may, Senator, but just another point on excise taxes, generally. I think if you will look at the relationship which the price of things like cigarettes and alcoholic beverages bear to the amount of excise tax on them, you will see that that level has either been constant for a long time, or in some cases actually has been reduced over time. So that we feel that moderate increases in those kinds of excise taxes do not, particularly given the discretionary nature of the expenditure, provide any kind of an inequitable burden on any taxpayer.

With regard to gasoline taxes, there are a variety of recommendations from various people inside and outside the Congress with respect to increases in the gasoline tax. Some of those we would probably view as being oriented more toward trying to effect energy consumption than raise revenue. Our view is very much the latter. Our recommendation of a 20-cent increase in the gasoline tax is only a recommended revenue option which we do not think would have any significant effect upon energy consumption, which a much higher increase in the gas tax might have. Arriving at that specific recommendation, we tried to stay on the lower side of an increase, feeling that at that level it would not provide a major penalty to anybody in the society.

Chairman Sasser. Senator Conrad.

Senator Conrad. Thank you, Mr. Chairman.

Before I proceed with my questions, I would like to formally indicate how pleased I am to have you as Chairman of this committee. I think already you are getting some sense of what a difficult challenge this is going to be, because obviously, we all come to this table with different perceptions of how to solve what some of us think is the overriding challenge to our country today. But I don't think anyone on this committee is better-positioned to form agreements and compromise than is the Senator from Tennessee, so I am looking forward to working with him in his new role as Chairman of this committee.

Mr. Chairman, I am glad that the Senator from Texas raised the question of equity. I find it curious that he raises the question of equity and then immediately attacks the notion of asking everybody to pay what they legitimately owe, because we are failing to do that today.

The tax gap which the commission's work refers to has indicated that there is some $100 billion a year that is owed to the Treasury that is not being paid. I would like to know where the equity is to those who pay what they legitimately owe when we allow some to escape. I would like to know what the equity is when we know according to this report, that only 6 percent of wage income goes unreported, and 50 percent of capital gains income goes unreported. One-sixth of dividend and interest income goes unreported, while only 6 percent of wage income goes unreported. Where is the equity in that?

I would, on the other hand, agree with the Senator from Texas on the equity of an increase in the gas tax, and pose the question to the members of the panel on their recommendation to increase the gas tax. That recommendation would ask the people of my State, a sparsely-populated, very large State, to pay twice as much for deficit reduction as those in States where people drive less, and drive fewer miles to get to work and do their business.

I really do wonder where the equity is in using a gas tax to deal with the question of budget deficits.

Mr. ONG. Senator Conrad, let me respond to that. Again, I think it is difficult in attacking as global a problem as the budget deficit to do so without calling up a number of items on both the Government spending side and the revenue side and looking at them, and then in the aggregate coming up with a collection of actions to reduce or contract spending and to increase revenue that, again in the aggregate, will make a meaningful contribution toward beginning to solve the problem.

It is, I think, what you and Senator Gramm are perhaps rightly pointing out to us, that individual recommendations we have made may not stand the test of equity or some other test which is appropriate to apply to them.

My answer to that is not to defend a specific recommendation like what is the equity of a 20-cent increase in the gasoline tax, and is it not true that it has a different impact on different people in different parts of the country. I would not for a minute begin to argue that point with you or Senator Gramm or anyone else.

I think it is for that very reason that we have in our recommendations overall tried to propose a variety of things that we think could be done to control spending, to increase revenues, in the hope that that or some similar combination of actions can be devised and agreed upon within the Congress and with the Administration and put into action.

It may be that the increase in the gasoline tax is so serious a breach of equity as it applies to taxpayers across the country that it is not a good idea. That, I think, is the function of the Congress to decide, you and your colleagues, not us. But we put it forward because it is part of the tax system, it is something that can be done now, it is a lever that can be pulled that would result in a substantial expansion of revenue, and we think it is very well worth looking at.

We are not trying to conclude that it is something that absolutely must be done. We are trying to offer choices. I would only suggest that just as the individual members of our council had to engage in a substantial amount of compromise in order to arrive at a package which we think credibly addresses the problem, clearly that same kind of approach is going to have to take place in the Congress.

Dr. **Duffey**. I would point out, too, that in the report, we linked that tax on the Highway Trust Fund to its original purpose in terms of addressing the problems of infrastructure. My testimony points out that a recent Government report stressed the fact that 40 percent of all the urban and principal roads in the country have now been classified as either in fair or poor condition, and more than 40 percent of the Nation's 576,000 bridges are either structurally deficient or obsolescent.

There are some playbacks for consumers of transportation in relating the tax directly to the need for infrastructure improvements and urging that, contrary to the present practice, the trust fund be used for that purpose.

Senator **Conrad**. I would make the observation that to the extent gas tax revenue is used for deficit reduction, it becomes unfair to those who, of necessity, are required to drive much longer distances and to consume twice as much gasoline as the national average. That is true of my State and perhaps true of Senator Gramm's State as well.

Mr. **Ong**. Well, we do feel, as Dr. Duffey has just said, that at least a portion of any increase in that tax should go into the trust fund so it would directly benefit infrastructure, which might even be of greater proportional advantage to people who do more driving.

Chairman **Sasser**. Thank you, Senator Conrad.

Senator **Bond**. Thank you, Mr. Chairman.

I would like to join Senator Conrad in congratulating you on assuming the chairmanship of this committee. I am delighted to be joining you.

Chairman **Sasser**. Thank you.

Senator **Bond**. I express our appreciation to our witnesses here today and to the people on the council who have worked so hard. I hope that you will not take the perhaps strong views demonstrated in the questions already asked and those yet to come as any lack of appreciation for the good work that you have put in.

I would associate myself with the remarks that Senator Conrad and Senator Gramm have made about the gasoline tax and would point out that to the extent that it is expended for the purposes of the trust fund, it does not reduce the deficit. But it does, I think, speak to a point that Chancellor Duffey raised, and that is, we do not have a capital budget. You said this is all going for current consumption. But as you well recognize, there are many elements of Federal spending that are going into long-term or longer-term improvements.

A very quick question. Would the Council advocate a capital budget? Do you think that makes sense for the United States?

Dr. **Duffey**. We discussed this at the beginning of our deliberations, I do think we came to a conclusion about it, John.

Mr. **Ong**. I think the general consensus was that a capital budget probably was a good idea. I think the council would view anything that introduced regularity and a longer time horizon into the public spending arena would be positive, whether it is multi-year budgeting, a capital budget, a somewhat different approach to the budgeting process itself. Any of those things—while we did not try to make specific endorsements of one or the other, I think the sense of our group would be that all of those are positive because they focus people's attention on longer-term issues.

Senator **Bond**. I would agree with you that there are many commonsense elements needed, particularly in the Federal budgeting and appropriation process. I am not sure how many of them we can achieve at one.

But I noted, Chancellor Duffey, on page 12 of your testimony that you said we need to explore major changes, perhaps, in the Tax Code which would reorient American thinking away from consumption and toward increased savings and investment. I assume you would agree with the basic proposition that I adhere to, and that is if you tax something, you get less of it; if you take the taxes off of it, you get more of it.

Under this scenario, based on your thesis, why haven't you suggested a broad-based consumption tax with some exclusions for food, housing and other necessities?

Dr. **Duffey**. We spent a number of hours talking about a consumption tax, comparing our views, consulting with others. We felt that we did not have enough understanding of its possible impact. Some were concerned about the regressive nature of the tax, although I think that we had some people around the table who unpredictably moved—as I think many Americans are who have thought about this have—in the direction of a consumption tax. It is simple, and it has quite an impact in raising revenues.

We could not come to the sense that we understood its impact clearly enough yet to make a recommendation.

Senator **Bond**. I was disappointed that you chose to go with the gasoline tax recommendation, because I think we could point out some problems there.

Let me move on to a more basic point, and I would like both of you to comment on it. I am generally concerned about the call for increased taxes, and I note even in some of your spending caps, you include higher taxes on Social Security recipients and medicare payments as part of spending reductions, when actually they are revenue-raisers.

As I look back over the charts, I see in the 1973–1974 period, Federal spending was roughly 19 percent of GNP. That was the time, which I happen to think was not coincidental, of the adoption of the Budget Improvement and Impoundment Control Act——

Chairman **Sasser**. What year was that, Senator Bond?

Senator **Bond**. Seventy-four; 19.2 in 1973; 19.0 in 1974. It has gotten as high as 24.3 percent. Now it is running at about 22 percent. I know that State and local governments are holding even, maybe slightly going up.

I am very much concerned that we should assume that we have to increase that Federal share by increasing taxes and increasing spending at the Federal Government level rather than at least holding that level or bringing it back down to the more customary levels. And I would ask your comments on that.

Mr. Ong. Obviously, I think our group would not—I have to be careful in stating my personal views and that of the group, because the group is a large and very representative one—but I do not think we would argue with you that perhaps consumption of a smaller portion of the gross national product by the public sector would be a favorable development.

We looked at the issue, though, not in those terms, but simply in the terms of trying to bring it into a better balance between revenue and spending. Obviously, it is the work of our representative Government, particularly the legislative branch, whether at the State or the national level, to determine what level of governmental public sector intervention there ought to be in the society and in the economy. That is a question of policy, and of course once those policy decisions are made, they then have some financial consequences.

I think the Council views it as beyond our scope to suggest what the limits of public policy ought to be. What we are saying is that whatever those limits are, we feel that financing public spending by a deficit to a substantial degree is something for which we pay an inadmissible price over time, and therefore there has to be more of an equation between the two.

Trying to decide at what particular level of gross national product that public sector activity should be set at, I think is probably beyond our compass.

Senator Bond. If I may ask the Chairman's indulgence, just to suggest one item that I think I would ask you to get back to us on if you can get an answer; I will not ask you for the answer here. But I wonder if you could take a look at the effective tax rate of the corporations which make up the council and suggest to us how much of an increase in that effective tax rate the members think would be appropriate and how it should be achieved to make a significant reduction in the deficit without curbing net business investment, which I happen to think is very important.

The political fact of life is if you ask for additional taxes, business is going to get them; and how much can you take and still maintain anywhere from 11½ to 12½ percent real business fixed investment that we have of GNP. Personally, I think that ought to be higher. I would be interested in having a letter or communication from you, if you and the Council members have further thoughts on it.

I thank the Chairman.

Chairman Sasser. Thank you, Senator Bond.

[The letter requested by Senator Bond follows:]

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John D. Ong
Chairman of the Board

February 16, 1989

The Honorable Christopher Bond
Hart Senate Office Building
Washington, D.C. 20514

Dear Senator Bond:

I appreciated the opportunity to testify on January 17 before the Senate Budget Committee on the Council on Competitiveness' fiscal policy program.

During that hearing, you asked me to supply you with information on the effective tax rates of the Council's corporate membership and to advise you as to what level of tax increase corporations could assume without adversely affecting investment. We have specifically analyzed a couple of different methods for calculating effective corporate tax rates. First, we reviewed the recently published report, "Effective Corporate Tax Rates 1987", published by Tax Analysts. Comparing our corporate members with their 1,000 company survey, we found our members had an almost identical effective tax rate (24.85 percent to 24.72 percent). We also reviewed statistics published by the Department of Commerce/Bureau of Economic Analysis. While we were not able to break out our corporate members individually in this listing, it showed that the 1986 average effective tax rate on corporations was 33.4 percent of total profits. This effective tax rate is the highest since 1972, when the effective tax rate was 35.2 percent.

In the Council's fiscal policy report, we recommend that if policymakers determine, as we have, that revenues are required to reduce the deficit, that they choose from a menu of options that we have developed. Included in this menu is an option to raise approximately $5 billion in additional revenues from corporations in FY 1993. Using the August 1988 CBO revenue assumptions upon which our recommendations were based, this would represent a 3.6 percent increase over projected corporate taxes for FY 1993. Given the major tax increase that corporate America incurred as a result of the 1986 Tax Reform Act, the $5 billion in additional corporate taxes was the maximum that we determined could be contributed to deficit reduction without adversely affecting corporate investment decisions. In our report, we also suggest that this additional corporate revenue should be derived from broadening the corporate tax base. The Council recognizes that there are tax code provisions that permit specific business taxpayers to reduce or avoid tax payments. The Council encourages elimination of those provisions, except for those that have a positive impact on productivity, exports or efforts to commercialize technology.

We would be pleased to discuss these issues with you and your staff in additional detail should you have further questions.

With best wishes.

Sincerely,

John Ong

John D. Ong

Chairman **Sasser**. I want to express my appreciation for your kind comments and also indicate my pleasure that you are going to be a new member of this committee. We look forward to working with you, and I think you will have some very meaningful and worthwhile contributions to make.

Senator Sanford.

Senator **Sanford**. Thank you very much.

I, too, must say how delighted I am that you are the Chairman of this committee. You are starting right now with imagination and initiative in getting at some of the basic problems.

During the 101st Congress we must be willing to make difficult choices in an honest and straightforward manner. We must begin to look at the true size of our deficits and the real problem of debt. We should not continue paying in excess of $200 billion annually on interest to service that debt. We need to invest more in our cities and towns. We need to begin spending that money on our future—on education and research, instead of continuing to spend it on the past as we now do.

Because of this, I think the work of the Council on Competitiveness can be so important. I want to thank the members of the Council on Competitiveness. I think the council has done an excellent job of pointing the solutions in the proper direction. I am not sure that we can get there from here by these recommendations alone, but at least we are looking in the right direction.

I always enjoy my distinguished colleague from Texas, who I regard to be a very fine economist. But like all economists, I think one of our problems is that we get tied up talking about aggregates, and we get confused in talking about taxes in the aggregate, because taxes are coming for Social Security and have no real relation to the deficits. And those people out there in Mule Shoe and Dead Horse would not quite understand being told, "You are not really broke just because you cannot pay your bills."

Gramm-Rudman actually is based on a cover-up that will not last, and consequently, I want to raise this question with the commission, because I think it is fundamental.

You show us working toward the Gramm-Rudman-Hollings deficit targets of zero in 1993. You must know that we will not be close to that zero figure, because Gramm-Rudman covers up the real deficit. It has had some good effects. G-R-H has caused some restraints in spending, and has proved the point of order can enforce budget discipline. I think that has been a very good effect. But it has not taken us toward zero, because it depend on the accumulation of trust funds, especially of social security.

If you add another line to your chart, below where you have listed "Deficit", "CBO Deficit", "Council Reduction", "Revised Deficit", "G-R-H Deficit Target", "Required Revenues" and "Interest Savings" showing debt, you would find in 1990 that debt would be $3.1 trillion.

Now, you would think if we were reducing deficits, we would be reducing debt. But we are not, because the very nature is that we are not reducing real debt; we are simply covering it up with the climbing trust fund reserves. And in the budget projections they would carry the debt from $3.1 trillion at the end of 1990 to fiscal year 1991 of about $3.3 trillion to fiscal 1992 of $3.55 trillion, and to

1993 when theoretically, under Gramm-Rudman, we reach zero, we will be at $3.8 trillion, moving rapidly toward another trillion dollars on top of the $3 trillion that we have now.

Now, have you all contemplated the seriousness of the rising debt as distinguished from the deficit as counted for?

Mr. **Ong**. Senator, we clearly do not disagree with you with regard to the effect of counting the Social Security Trust Fund in the deficit calculation. We would not argue with—and in fact, I think refer to—this $200 billion deficit level. So no disagreement there at all.

Specifically to the question of the resultant debt level, we have not addressed that. But clearly, as you say, the longer the current deficit situation prevails, the more serious that problem becomes.

Our report, our recommendations, represent, as we put it, a down-payment, an initiation, a first step, in addressing this question of imbalance in the financing of public expenditures at the Federal level. We do not pretend for a minute that what we have recommended solves the problem. It clearly does not. There would still be a substantial budget deficit. Even if everything we recommended was put into the works, and if it all worked as we estimate it will, there would still be a problem. But we think that this is not going to be a problem that is solved in a hurry.

Our recommendation is to make a start now and to make significant progress by fiscal year 1993 and then, as we say somewhere in our report—I cannot cite it to you exactly—we feel that there should be a second stage of addressing this issue beginning in 1994.

Obviously, there are some things that can happen over those intervening years that will make the problem either greater or a little less serious than it is, the operation of the economy being the most important of those.

But no, we have not specifically addressed the issue of national debt as such, but in addressing the current deficit, we feel we are doing that over the long run.

Senator **Sanford**. My time is up for questioning, but if Chancellor Duffey has a comment, I am sure the Chairman would let him.

Dr. **Duffey**. I think we have attempted to bring together a complex of proposals, Senator. As I recall in 1984, Senator Howard Baker said of the tax bill that year in commenting on it, "It was a riverboat gamble." I suppose we could differ around the table as to what it looks like today or whether the cards are finally down on the table. But we believe that not to send any signal, not to begin any concerted effort to attack the deficit is for our Nation, a very significant gamble at this stage.

Chairman **Sasser**. Thank you, Senator Sanford.

Gentlemen, I might share with my colleagues and the panel here some statistics that the staff has handed me. Dr. Duffey was indicating that my esteemed former colleague, Senator Baker, said that the tax cut was a "riverboat gamble". If you look at these statistics, you see it really has not made much difference, apparently.

In 1980, the taxes as a percent of GNP stood at 19.4 percent. In 1987, taxes as a percent of GNP stood at 19.3 percent; projected in 1989 to be 19.1 percent. Lay down spending as a percent of GNP, and you find in 1980, spending as a percent of GNP was 22.1 percent; in 1987, 22.6 percent; projected to be 22.2 percent in 1989.

One percent of GNP increase in spending is a direct result of increased interest on the national debt. And you look down at the deficit figures. In 1980, they were 2.8 percent of GNP; in 1987, 3.4 percent of GNP; in 1989, they are projected to be 3.2 percent of GNP.

So in proportion to GNP, the only thing that has grown significantly is the deficit. And that is why I think, gentlemen, your council's report is so important, because it lays out, I think, the roots for attack on this deficit.

It is not something we could all agree on. I think you have heard today that there are members of this panel who are not very enamored of the gasoline tax. There are members of this panel from more urban States who are not with us today who might look more favorably on a gasoline tax than those of us from rural States who have constituents who travel for long distances.

The question was raised about the disparity between deficit reduction by way of raising revenues and deficit reduction by way of cuts in spending. As I understand the council's report, you are leaving some room in deficit reduction for spending so that we can make investments in education, make investments in science, basic science—like the Super Collider, for example. So the long range thrust of your report, if I am not mistaken, gentlemen, is an effort to try to make the U.S. economy more competitive.

Dr. Duffey, you make a point very eloquently in your prepared testimony about investing in the human resources of this country, and you express a concern about the undernourished, uneducated and unskilled children of this generation and future generations. In 1970, we have almost 6 million children who will live in families with incomes less than one-half of the poverty line. By the year 2000, one-third of all elementary and secondary students will come from racial minority backgrounds.

There is great concern being expressed about the under-class that is growing in this country that it may become permanent.

Would you recommend a larger investment in the training of unskilled workers, and what kind of priority should this receive? Will there be a market for unskilled workers?

Dr. **Duffey**. The first, most immediate question to address is the implications of the changes in the work force to which you have alluded to, Mr. Chairman. That means that some investments which can clearly be established as making a difference in terms of nutrition, Head Start and other items. I believe we have to begin at that level.

In the past many approached these questions as matters of justice and compassion. Today we have the additional imperative of economic necessity.

Senator Gramm talked about a 3-percent growth in the GNP. The last two quarters have been, I think, about 2.5. We all hope for that kind of growth. The argument we are making is that these investments are essential to that growth, and obviously, that growth is essential to being able to afford the things that we feel are important to the quality of life of the Nation.

Chairman **Sasser**. Do you wish to amplify on that at all, Mr. Ong?

Mr. **Ong**. No; thank you.

Chairman **Sasser**. Let me ask you this question. As a manufacturer, what are you finding with regard to the work force that you and your colleagues seek to recruit to run your factories and run your assembly lines? I read that industry has embarked on a significant program of re-educating workers. I read that on occasion they find the workers they employ do not have the elementary skills in language, mathematics, et cetera, that are necessary. Is this of concern in the business community, and really, how much of industry's or business resources are being allocated to doing the job that the educational system was thought to be doing?

Mr. **Ong**. The question of the quality of the work force now and in the future, I would say is probably as much in the front of the minds of businessmen as any issue in the country today.

We all know individually, from our experience, that we are having increasing difficulty in finding the number and quality of workers that we need, and only a little examination of the demographics is needed to demonstrate to us that that problem, however substantial it may be today, is going to be aggravated considerably in future years.

We feel it is one of the growing, fundamental problems that the country faces.

I think it is quite the case that American industry—I do not have any statistics offhand to recite to you—but American industry, particularly the industrial companies, the manufacturing companies, are indeed devoting more and more of their budgets every year for training. But having said that, I think it is also the conviction of most businessmen that the private sector, that industrial companies, are not institutions that are well-designed to provide basic education to people.

We can train for specific skills, but we really are not institutionally a good way to address the question of fundamental skills in the work force. That is traditionally a public sector activity, usually conducted at the State/local level, and we feel it should be.

We are all concerned about the quality of that training and about the direction of the secondary and elementary schools, as Dr. Duffey testified earlier. And it is for that reason that even though our immediate focus is on the reduction of the deficit, we feel compelled to include recommendations about in the longer-term, shifting priorities so that more money can be spent in areas that address this very essential problem.

Chairman **Sasser**. Thank you.

Senator Gramm.

Senator **Gramm**. Mr. Chairman, I want to thank you for your patience today.

I would just like to sum up with a couple of remarks. And I should note I am working off this little summary sheet that was provided by the Council on Competitiveness. It talks about goals, spending caps and revenues.

Let me tell you, Mr. Ong, what concerns me about this. And the reason I focused on the aggregate today is to try to put it in the context of the big picture. Let me just review a little bit of history, if I may.

In 1981, Federal revenues as a percentage of GNP had reached the highest level since the peak of the war mobilization in 1944. In

1944, revenues as a percent of GNP were 21.7 percent. Today revenues as a percentage of GNP are 19 percent.

As I look at your proposal which proposes reductions in the rate of growth of spending as compared to the baseline, by 1993, of $13 billion in defense, $26 billion in entitlements, and $9 billion in non-entitlements, I come up with $48 billion worth of savings, and your goal of reducing the deficit by $120 billion, which is where I get the $72 billion of revenues.

I might add, Mr. Duffey, I am not the one who is assuming it at 3 percent real growth—you are assuming it in your numbers, or else you do not get the results that you seek. Now, I think what ought to alarm us, and what ought to alarm all these good businesses that are supporting this proposal is that if you take that revenue increase, you are going to have Federal revenues as a percentage of GNP in 1993 of 20.2 percent—an increase in real terms as a percentage of GNP 6 percent above the current level. In fact, there will not be a year in American history if your vision for the future as recommended here were implemented, where Federal spending as a percentage of GNP were higher except in 1944, at the peak of the war effort.

And as I hear the talk about increasing savings, increasing investment—two goals that I totally support—I do not see how the largest Federal presence of any year except the peak of the war effort in 1944 is compatible with that.

Second, I am a strong believer that we over-invest in the next election and we under-invest in the next generation. I support everything that Mr. Duffey has said about education and investment in science and technology. The question is how are we going to pay for it. Are we going to pay for it by reordering priorities, by getting the Government out of the business of paying operating subsidies on mass transit, for example, or are we going to do it by simply making the Federal Government bigger?

And for the life of me, I cannot see how making the Federal Government bigger is going to achieve the other results that you seek. And I think this is especially something that ought to concern business when we see all over the world that other governments are moving in the other direction. Even the Soviet Union has rejected the idea that government control and government domination of resource allocation promotes economic growth.

Does it concern you—and assume, just to humor me, that my numbers are right—if in fact your proposal produced the second-highest level of taxes in American history, second only to 1944, and a 6-percent increase as a percentage of GNP as compared to now, would that concern you?

Mr. ONG. Senator, I cannot speak to your numbers, but I will accept your assumption, which is that they are correct. And I think my answer would be yes, that would concern me.

Incidentally, if I may digress on a specific point, I think the difference between my 48 and your 72 is our estimation of interest savings, which are, as you know, a very important part of the expenditure side, which would result over the 4-year period from the reductions in spending. That is where our difference comes about, just in point of fact.

But let me get back to your main point. If you read our report as advocating the assumption or the consumption of a larger percentage of the gross national product by Federal revenues, that is not what we are recommending. If that is the inevitable consequence of what we are recommending, then we are in error, because that is not where we are trying to go, quite clearly.

More specifically than that, I think I can state that the consensus of our council is very clearly that the primary attack on the deficit should be at the spending side. And if indeed it is possible to solve the problem, or even make a meaningful beginning in solving the problem, without raising additional revenues, I think we would endorse that heartily.

All that we have said is that in our deliberations and in observing the public debate, the positions taken by Members of Congress, by the new Administration, in talking with experts, observers of various aspects of the spending program, defense, entitlements and the like, we could not find a way that we felt was credible, feasible, to make a meaningful beginning in reducing the deficit by spending constraint or reduction alone.

But we, with reluctance, would advocate increasing revenues, and we would only advocate it, as I said very specifically—and I would just like to re-emphasize this—in an atmosphere in which spending caps and a commitment to spending reduction was ironclad on the part of both the Administration and the Congress. And if there is a way that this problem can be approached in a meaningful manner, with less revenue increases, we would be absolutely for that.

Senator **Gramm**. Mr. Chairman, if I could make one additional point, if you would indulge me, and then I will stop for the day.

I guess the point I feel that we have to keep in mind as we engage in this debate is that under the CBO baseline, which I am willing to accept only for purposes of this debate, we are already looking at revenues as a percentage of GNP growing from 19 percent last year to 19.5 percent. So we are already looking at a growing real tax burden under existing law.

And the point we have got to look at is if you are going to raise taxes above that 19.5 level, no matter how you try to work around it, the bottom line arithmetic is that the Government's burden on the economy in real terms as a percentage of gross production is going to go up. And this is assuming a rapidly growing economy, which may or may not happen.

Thank you.

Chairman **Sasser**. Senator Sanford?

Senator **Sanford**. Well, thank you very much.

Let me urge you to stick to your guns and not be worried about these aggregate predictions. When we start aggregating, we sometime get in trouble. Certainly, the tax burden going to increase scientific investment, or to increase educational opportunities, does not equate at all with taxes to support big government. That does not make the Government bigger or more powerful.

The truth of the matter is that if you look back at income and excise taxes over the last 20 years, and take out of that what can honestly be called a retirement investment—now, we call it "taxes" simply because that is the terminology that we picked up, but it is no more taxes than what you pay, Chancellor for your TIAA retirement fund. That is simply investing in retirement through a public program. That has nothing to do with taxes except in the broader terms of how much money is drawn out for that kind of a saving exercise.

If you look at the taxes paid that go to the Government, that go to the operation, you will see a much more favorable picture. You actually will see the rate having gone down substantially.

So you are working toward competitiveness. If we get a better level of competitiveness, we are not going to have to worry too much about the budget or the economy. If we are going to get there by education, then that is a good investment and worth the money. That is what you have said. I hope you will just continue to pursue this very thoughtful approach to getting America more competitive again.

Thank you.

Chairman SASSER. Thank you, Senator Sanford.

Gentlemen, thank you very much for your appearance here this morning and your testimony. It has been very helpful for this committee and will be helpful in our continuing deliberations; very illuminating. We are in your debt and those of your colleagues on the council for the long hours that you put into preparing this report, in your deliberations. And although, like some of my colleagues, I cannot agree with everything in the report, perhaps that is one thing that makes it so persuasive; there is a little bit that everybody does not like. I think you have made a real contribution to trying to deal with what I perceive to be the great problem of the decade of the 1990s—the budget deficit and the question of competitiveness of the U.S. economy.

Thank you very much.

[Whereupon, at 12:12 p.m., the committee was adjourned.]

COUNCIL
ON
COMPETITIVENESS

* * *

RECLAIMING THE AMERICAN DREAM:

FISCAL POLICIES FOR A COMPETITIVE NATION

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The Executive Committee of the Council on Competitiveness has reached general consensus on the main principles of this report. While agreeing with the basic principles, individual members of the Executive Committee may not necessarily agree with each specific finding and recommendation.

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PREFACE

The American Dream is a universally recognized metaphor for a better way of life — a steadily rising standard of living, decent and affordable housing, good schools for our children, high quality health care, a clean environment, the growth of economic and social opportunity, and the preservation and expansion of liberty.

The Dream was built on vision, sacrifice and hope. It was cultivated by families willing to postpone their immediate gratification for the promise of tomorrow, by parents willing to scrimp and save as a means of investing in their children's future. It was advanced by employers and employees who developed the most vibrant economic system the world has ever seen. And over the years, it has been nurtured by government leaders with the wisdom to make the far-sighted public investments needed to facilitate long-term growth.

Today, however, the prospect of a rapidly rising standard of living — with all of the attendant benefits for U.S. citizens — is at risk. U.S. fiscal policies not only are undermining our ability to compete in global markets, but stand as a constant reminder of our inability to address what all agree is our most pressing economic-policy problem: the multibillion-dollar federal budget deficit.

The United States is living beyond its means, the consequences of which are only now beginning to be broadly understood by the American people. By building up massive budget and trade deficits, we have been transformed almost overnight from the world's largest creditor into the world's largest debtor. Worse, because we have been unable or unwilling to make the investments needed to boost long-term productivity, we are prolonging our debtor status. We have put in peril the once-certain promise of a constantly rising standard of living. Our current prosperity cannot be sustained indefinitely unless the nation takes serious action to reduce the deficit.

The burden of our profligacy will fall most heavily on the next generations. Unless we act now, our children and grandchildren will be saddled with our current debt. Worse, their lives may be less productive unless we can find ways to finance the pro-competitive improvements — better schools and scientific and technological advancements — that would make it possible for them to achieve a better standard of living than we have enjoyed.

The responsibility does not rest with any single administration, political party or interest group. All of us —

government leaders and private citizens — have joined to create the current fiscal environment. And we must now all work together to develop effective remedies.

We are pleased that President-elect Bush agrees that reducing the federal budget deficit is our nation's top fiscal priority. The next few months provide the incoming Administration with an opportunity to refine its thinking on this complex problem. In that regard, we hope that our report assists in this sorting-out and consensus-building process.

Clearly, there are many ways to reduce the budget deficit. Council members' thinking has been shaped by two guiding principles. First, we have viewed the budget crisis through the lens of the broader competitiveness challenge facing America; thus, we consider deficit reduction primarily as the short-term foundation for the development of a longer-term fiscal policy that will advance American living standards and keep our economy strong well into the next century. It is not merely a question of balancing the federal budget, although that is the necessary first step. We must also take steps to tilt government spending toward programs that will improve our productivity in the long run; preserve the integrity of the Social Security Trust Fund, the nest egg for the next generation of retirees; and reorient the tax code to better support private saving and investment. Second, we have tried to recommend changes that ensure that all sectors contribute to the deficit-reduction effort.

A credible deficit-reduction package should involve average annual cuts of about $30 billion over the next four years. We believe it will be difficult to achieve that level of deficit reduction on the spending side alone — at least not without undermining the nation's long-term competitiveness or cutting some programs too deeply. However, we feel that the new Administration and Congress should design and put into effect a plan to reduce the deficit that reflects their policy positions. We urge that this be done cooperatively and with the highest priority. If a formula for deficit reduction without new revenues proves as elusive to the new Administration as it has to us, we hope the new President and Congress will consider the options advanced by the Council.

The first days of a new administration and Congress provide a unique opportunity for a cooperative approach to solving problems, challenges that in other seasons are considered intractable. But the window is narrow. And time is short.

Developing a pro-competitive fiscal policy will require some difficult and painful choices. Before the American people will be willing to support the measures needed to restore fiscal responsibility to our public policy, they must first understand the full dimensions of the problem. Developing that awareness will require political leadership of the highest order — in the White House and on Capitol Hill. We hope that our report adds to that understanding and provides a perspective that is helpful and supportive to these policymakers. And as representatives of the nation's business, higher education and labor communities, we are eager to work with the leaders of both parties in building the political consensus needed to take this essential step toward advancing America's competitive position in the world economy.

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EXECUTIVE SUMMARY

The United States faces serious fiscal problems which, unless confronted immediately, threaten to undermine other efforts to improve American competitiveness. Although the American people are aware generally of the most visible sign of the problem — large federal budget deficits — the full magnitude and meaning of the nation's fiscal emergency remain only dimly understood.

The nation's fiscal policy affects U.S. competitiveness in three critical ways. It influences the level of investment — public and private — in productivity-generating activities. It determines the extent to which the United States has to borrow abroad to finance this investment. And it affects the spending, saving and investment decisions of individuals and corporations. These decisions, in turn, help determine the macroeconomic environment in which U.S. firms and workers compete and generate the productivity increases needed to maintain rising living standards for American citizens.

This report raises and responds to four questions that are critical to the development of a fiscal policy that supports American competitiveness. What are the causes and consequence of America's fiscal-policy problems? What public-policy changes are needed to address the problem in the short term? How can policymakers reconcile the tensions that naturally exist between the need for sacrifices in the short term and the assurance of rising living standards over the longer term? And, what are those longer-term solutions that will help put the United States on a more solid financial footing well into the next century?

In presenting the Council's views, we are mindful of our limitations. We are business executives, educators and labor leaders — not budget analysts or economists. We recognize, too, that there are many ways to achieve the widely agreed-upon objective of reducing the federal budget deficit. Our recommendations represent only one set of options. Finally, the Council realizes that the ultimate solution will depend, in part, on the type of political compromises that President-elect Bush and the 101st Congress are uniquely positioned to make. It is precisely to assist them that the Council offers the following observations and recommendations.

Summary of Findings

The most pressing fiscal-policy challenge facing the United States is to reverse the decline of the national saving rate. Net national saving — the sum of individual and corporate saving, plus government surpluses or deficits — fell to approximately 2 percent of Gross National Product (GNP) in 1986 and 1987. That rate — about one-third the U.S. average of the 1970s and one-fifth the current average of the major industrialized countries — is far too low to finance the levels of domestic investment needed to bolster American competitiveness.

Low levels of investment, a by-product of low national saving, undermine U.S. competitiveness. Investment is the key to increased productivity, to good, high-paying jobs — and ultimately to a higher standard of living. Because America's principal competitors have invested more as a percentage of GNP than the United States, they have had higher productivity growth rates in the past few decades. The once-substantial U.S. lead in productivity has eroded considerably. Given that American investment has fallen to a postwar low in the 1980s — down to 4.8 percent of GNP — other countries could soon surpass America's productivity performance.

Because the United States saves so little, financing even the lower levels of domestic investment depends on massive inflows of foreign capital. Although the national saving rate in the 1980s has averaged only about 3.0 percent of GNP, U.S. investment has averaged about 4.8 percent. The saving-investment gap has been financed with foreign funds. Foreign capital is a mixed blessing. If used for productive investment, as opposed to merely facilitating consumption, it can enhance U.S. competitiveness. However, the repayment of principal and interest on growing levels of foreign debt will reduce future American living standards. It will cost the average family of four approximately $2,600 just to repay the principal on foreign debt incurred in 1987 alone. The inflow of foreign funds also contributes to the record current account and trade deficits that have become the very symbol of America's declining competitiveness. Low domestic saving, therefore, presents America with a cruel choice: either forgo productivity-enhancing investment or rely on foreign funds for those expenditures. Either way, the American standard of living may suffer.

The sharp decline in national saving has been caused primarily by surging federal budget deficits during the 1980s. Although the federal government has run a deficit every year since 1962, with the exception of 1969, the deficit has risen dramatically as a percentage of GNP this decade. In the 1960s, the deficit averaged 1.0 percent of GNP, rising to 2.1 percent of GNP in the 1970s and then ballooning to 4.2 percent of GNP in the 1980s. In some years, federal borrowing has absorbed almost two-thirds of all private domestic saving.

Recent efforts to reduce the budget deficit have been unsuccessful. *The deficit is increasing, not decreasing,* despite enactment of the Gramm-Rudman-Hollings legislation, which requires a balanced budget by FY 1993, and the Budget Summit Agreement, which was triggered by the October 1987 stock market collapse. Despite these efforts, the Congressional Budget Office (CBO) estimates that, excluding the Social Security Trust Fund surplus, the deficit will rise from $199 billion in FY 1989 to $220 billion by FY 1993. Only when the Trust Fund surplus is included does the projected deficit drop — from $148 billion in FY 1989 to $121 billion in FY 1993.

Using the Social Security Trust Fund surplus to mask the true size of the deficit causes two problems. First, this accounting sleight-of-hand undermines efforts to build the political consensus needed to make difficult deficit-reduction choices today. Worse, the surplus is intended to prefund the retirement of the large baby-boom generation. If it is used instead to help create the illusion of a balanced budget, when the baby boomers retire and the surplus disappears, the federal budget deficit will soar in the next century. Policymakers will be confronted with even more stark choices than they face today: sharply higher taxes, more draconian spending cuts, or massive borrowing. The prefunding plan was designed in 1983 to avoid these kinds of choices.

The debate over the cause of the federal deficit has been misleading and oversimplified, with some blaming excessive spending and others inadequate taxation. One point is clear: historical levels of spending and revenues, while important, should not be viewed as rigid guides for current or future levels of spending and taxation.

The changing composition of spending and revenues begins to suggest steps needed to resolve current fiscal problems. Since 1962, the fastest-rising outlays have been for such truly uncontrollable expenses as net interest payments on the debt. The fastest-growing revenues have been social insurance taxes, which are designed to pay for Social Security benefits, not to fund the general account. Spending for defense and non-defense discretionary programs has fallen in the 1980s, but revenues to pay for these programs have fallen even more.

If competitiveness objectives are to increase levels of national investment, reduce the nation's growing dependence upon foreign capital and reverse the trade deficit, then tax finance is preferable to deficit finance. Financing federal spending through deficit finance has a more adverse effect on the above-stated goals than tax finance. Increased taxes affect both the purchase of consumable goods (consumption) and the purchase of capital goods (investment). Deficit finance, on the other hand, has little effect on consumption but instead falls almost exclusively on investment. While foreign capital inflows have kept investment at somewhat higher levels than would be afforded given current saving levels, these inflows compromise achievement of other competitiveness goals: reducing America's dependence upon foreign capital and reversing the trade deficits.

In addition to draining domestic saving through large federal budget deficits, fiscal policy can affect U.S. productivity, economic

growth and competitiveness in two other ways — through the allocation of resources and the raising of revenues. On the spending side of the ledger, programs that support scientific and technological advancement, human resource development, and infrastructure maintenance and construction underpin the nation's long-term competitiveness. These programs are often neglected in favor of spending for consumption-oriented programs. On the revenue side, the structure of the tax code influences individual and corporate decisions to spend, save and invest. The existing code favors consumption rather than saving and investment.

Addressing the fundamental cause of the deficit problem will require policymakers to acknowledge and attempt to reconcile the tensions that exist between the notion of short-term economies and longer-term increases in living standards. The Council believes that a key element of this reconciliation is a perception that all groups capable of sharing in the effort to reduce the deficit do so. It also depends upon a deeper understanding of the longer-term gains to be realized through the deficit-reduction effort.

Summary of Recommendations

The Council proposes that the new President and Congress consider a two-phase approach to building a pro-competitive fiscal policy. In the short term, the top fiscal priority should be to reduce the federal budget deficit. No other single action will have such a dramatic effect on boosting national saving to levels high enough to finance much-needed domestic investment.

Over the longer term, the Council believes that serious attention must be given to reorienting American thinking — both of the government and the individual — away from consumption toward saving and investment. This will involve action on three fronts: a shift in spending priorities toward pro-competitive investments in people, technology and the nation's infrastructure; efforts to ensure the integrity of the Social Security Trust Fund; and a reorientation of the tax code to promote private saving and investment.

The Council believes that President-elect Bush should be afforded time to further examine options to reduce the deficit and, working with the Congress, design a program for the American people. The Council advances its recommendations for a pro-competitive fiscal policy as an attempt to assist in this effort.

A short-term deficit-reduction package

The Council believes that the federal budget deficit should be reduced by approximately $120 billion by FY 1993, or average annual reductions of $30 billion. This effort would bring the nation part of the way toward balancing the federal budget without relying on the Social Security Trust Fund surpluses, based upon CBO's assumptions of economic growth, interest rates, and inflation. U.S. success in bringing the dollar down from its record high in the mid-1980s has opened a unique opportunity for a successful transition to a pro-competitive fiscal policy without undermining overall economic demand. The proposed annual deficit-reduction target of $30 billion matches this year's improvement in the trade deficit and is also the amount of new capacity that can be brought on-line in export- and import-competing industries. New export demand, in particular, can substitute for the demand previously provided by large deficits, thus reducing the threat of recession from this program. Thus, related policies that foster continued rapid improvements in the trade deficit and high levels of investment in new capacity are essential to this transition. As pressure on financial markets is reduced through deficit reduction, the Federal Reserve Board should allow real interest rates to fall, facilitating rapid business investment in human and physical capital and making it easier to manage further movement in the dollar's value and steady improvements in the trade deficit.

The Council believes that policymakers should be guided by three principles in their efforts to reduce the deficit. First, the short-term burden of deficit reduction should be widely shared. This is essential to reconciling tensions that may exist between short- and longer-term decisions of the government and individuals to spend, save and invest. Second, the nation's historic commitment to equity should be sustained. And finally, attempts must be made to minimize adverse effects on private saving and investment.

In slowing the growth of federal spending, the Council believes that all programs, with the exception of means-tested programs, should be reviewed for possible savings. In recent years, budget cuts have fallen disproportionately in two areas — defense and non-defense discretionary spending — which account for less than 40 percent of federal outlays. Many entitlement programs have been exempted from cuts altogether. The Council feels that it will be difficult to achieve credible spending cuts if 60 percent of spending categories are excluded from deficit-reduction efforts. For that reason, the Council believes that entitlements — including politically sensitive Social Security and Medicare — should be considered for budget savings.

The Council believes that spending caps are the most effective method for restraining federal spending, and urges that the next President and Congress use this tool to control federal spending. By setting broad four-year spending caps for each major budget area — defense, entitlements and mandatory spending, and non-defense discretionary spending — policymakers agree that outlays will not exceed a preset level, despite underlying economic changes. If the economy grows faster than anticipated, the deficit is reduced more quickly; if the economy slows down, structural deficit reduction is not delayed. Within each major category, policymakers would retain the flexibility to increase or decrease outlays for specific programs. And while some flexibility should be retained in the event of a recession, spending caps have the advantage of providing real budget restraints to control spending during periods of normal economic growth.

Spending caps and options to reduce spending

There are a number of ways by which the deficit could be reduced. Having reviewed a wide range of options, the Council has developed a series of spending caps for the three major budget categories and examples of how those spending caps could be achieved. The caps represent proportional decreases from what the CBO estimates spending will be that year — in FY 1993, the caps represent a 3.7 percent reduction from the baseline estimate for that year. The Council estimates that together these caps could reduce federal spending by approximately $48 billion by FY 1993.

Defense. Cap defense spending at $307 billion in FY 1990, $316 billion in FY 1991, $325 billion in FY 1992 and $335 billion in FY 1993. The Council recognizes that defense spending has been reduced for the past four years. But as the largest portion of federal spending controlled through the appropriations process, defense cannot be exempted from additional controls. The Council believes that savings can be achieved primarily through improved national-security strategies and procurement efficiencies along the lines recommended by the Packard Commission.

Entitlements and mandatory spending. Cap spending at $567 billion in FY 1990, $598 billion in FY 1991, $636 billion in FY 1992 and $676 billion in FY 1993. Entitlements and other mandatory spending represent the largest single category of federal spending, accounting for nearly half of federal spending in FY 1989. For that reason, the Council recommends that this category not be exempted from cuts; to do so could require disproportionate reductions elsewhere. To maintain the nation's commitment to equity, however, the Council believes that entitlement reductions should be carefully targeted only to those who can afford to share the burden of deficit reduction. In that regard, means-tested programs designed for low-income individuals and families should be exempt. These programs range from Medicaid and food stamps to pensions for disabled veterans. The Council offers the following priorities for curbing spending in the other entitlement categories:

- **Non-means-tested programs.** The Council suggests consideration of several program changes to reduce spending growth. These include: increasing taxes on benefits of higher-income Social Security recipients; controlling the rate of Medicare cost increases; and requiring higher-income Medicare beneficiaries to pay a higher share of program costs.
- **Retirement and disability programs.** The Council suggests reducing the cost of federal and military retirement programs. One option

that merits special attention would be to restrict the cost-of-living-adjustment for non-disabled retirees under the age of 62 to reduce the incentive for early retirement from the work force.

- **Farm-price supports.** The Council suggests modifying the farm-price-support program to restore greater reliance on market forces. This could be accomplished by either reducing agricultural target prices or reducing the base upon which deficiency payments are calculated.

Non-defense discretionary programs. Cap spending at $202 billion in FY 1990, $203 billion in FY 1991, $207 billion in FY 1992 and $212 billion in FY 1993. This category includes funding for the federal civilian agencies, plus programs that support education, research and development, infrastructure and housing, among others. The Council suggests that program changes should be driven by two basic objectives: to reduce or eliminate subsidies to sectors that no longer need them; and to require users to pay fees that more accurately reflect the true cost of these services.

Revenue-raising options

The Council recognizes that under the CBO's assumptions about economic growth, employment and interest rates, reducing the deficit on the spending side of the ledger alone would require draconian reductions in federal spending. Federal spending would have to be cut in real terms by 1.5 to 2 percent across the board.

The Council believes that it will be difficult to close the deficit gap absent additional revenues without undermining efforts to improve American competitiveness. If a formula for deficit reduction without new revenues proves as elusive to the new Administration as it has to the Council, we urge the President and the new Congress to consider the options below. We estimate that taken together these could raise more than $70 billion in additional revenues by FY 1993. Not all of these revenue options would be needed to meet the short-term goal of significantly reducing the deficit. Given the $48 billion in spending cuts put forward by the Council and related interest savings, increased revenues of approximately $48 billion would be required in FY 1993 to meet the short-term deficit goal.

Raise excise taxes. Over the past years, the effective tax rate on cigarettes and alcohol has deteriorated significantly as a result of inflation. Even partially restoring rates could raise approximately $8 billion per year in FY 1993.

Raise motor-fuels taxes. An increase in motor-fuels taxes would raise approximately $1 billion for every 1-cent increase. The Council suggests that motor-fuels taxes be increased by no more than 20 cents per gallon. These taxes could be phased in over the four-year period between FY 1990 and FY 1993. Dedicating a portion of new motor-fuels revenues to the Highway Trust Fund for infrastructure development and introducing a mechanism to address regressivity problems would reduce somewhat the amount of receipts for deficit reduction derived from this tax.

Broaden the tax base — both individual and corporate. Although the 1986 Tax Reform Act removed many loopholes and deductions, major exceptions for individuals include the deductibility of home-equity loan interest and mortgage interest for vacation homes. Limiting home-equity loan deductibility to loans used only for home improvement or education expenses and phasing out the deductibility of mortgage interest on vacation homes would raise approximately $3 billion in FY 1993.

Measures to broaden the corporate tax base should also be considered. Existing tax code provisions permit specific business taxpayers to reduce or avoid tax payments. The Council encourages the new Administration and Congress to eliminate those provisions, except for those that have a positive impact on productivity, exports or efforts to commercialize technology. These changes should be designed to contribute $5 billion in FY 1993.

Improve tax compliance. A program to improve compliance by raising audit rates to 1970 levels, imposing additional withholding requirements on dividend and interest income, and requiring information reporting on capital gains could increase tax collections by at least $5 billion after several years.

Institute an explicit 33-percent income-tax rate and expand it to upper-income individuals. This option would make the current hidden 33-percent tax rate explicit and expand it to all families earning more than $200,350 per year. This option would affect about 600,000 high-income taxpayers and would raise approximately $7 billion in FY 1993.

Impose a temporary surtax on individual income. This option would impose a temporary 5-percent surtax on individual income — with the exception of income derived from long-term capital-gains activities — to be sunsetted in FY 1993. The surtax would raise the individual tax rates from 15, 28 and 33 percent to 15.75, 29.5 and 34.6 percent, respectively. Increased revenues of approximately $25 billion could be generated in FY 1993.

A long-term reorientation of fiscal policy

To build on the accomplishments of short-term deficit reduction and lay the foundation for U.S. competitiveness into the 21st century, the Council recommends that policymakers address three additional issues.

The Council recommends that federal spending priorities be oriented toward programs that improve productivity, notably science and technology, education and training, and infrastructure. Inadequate attention to these "building blocks of competitiveness" has contributed to the decline in America's technological leadership, the widening gap between the skills needed for future jobs and the capabilities of the work force, and the deterioration of the nation's infrastructure. Bolstering these areas will require additional federal funds. Once the process of credible deficit reduction is underway and effective delivery systems are established, the following steps should be taken:

- Strengthen the federal role in science and technology by doubling the National Science Foundation (NSF) budget, increasing NSF funding for programs to encourage the development of science and engineering faculty, and providing additional federal resources to modernize university research facilities.

- Make additional funding available for human resource development, with emphasis on programs to serve the economically disadvantaged, to strengthen math and science education, and to provide training and employment services to dislocated workers.

- Maintain and improve the infrastructure of bridges, roads, airports and waterways in three basic ways: use part of the proposed motor-fuels tax increase to finance highway repairs; maintain funding levels for infrastructure at real growth rates; and ensure that Highway Trust Fund resources are earmarked for infrastructure improvements and not used to reduce the federal budget deficit.

The structural imbalance between federal non-Social Security revenues and spending should be eliminated so that the Social Security Trust Fund surplus can be used for its intended purpose: to prefund the retirement of the baby-boom generation. The Council urges that steps be taken to prevent the surplus from being used to continue masking the true size of the deficit — or to support other federal programs, reduce payroll taxes or expand Social Security benefits. If the surplus is misused today, once the baby boomers begin retiring early next century, the nation will be confronted with three unattractive choices: reduce spending drastically, increase taxes sharply or increase government borrowing significantly.

The Council appreciates that preserving the Trust Fund will not come cheaply. Even if all of the Council's proposed short-term spending and revenue options are adopted, excluding the Trust Fund from deficit calculations will result in a deficit of approximately $110 billion by FY 1994. The Council recognizes that policymakers then will be challenged to begin a new round of deficit reduction. If additional revenues are needed, the Council believes that three options should be considered: a surtax, increased income tax rates or a consumption tax. A consumption tax could quickly address the problem because of its ability to raise large amounts of revenue with the least amount of distortion to the economy. However, the Council believes a number of issues would have to be addressed before instituting such a tax. These include determining what type of consumption tax would best serve U.S. competitiveness goals and most importantly, redressing the regressivity problem.

The Council encourages policymakers to consider restructuring the tax code to remove biases that favor consumption and discourage private saving and investment. While record federal budget deficits are the principal factor underlying low levels of national saving, private saving also has fallen. The Council supports removing incentives in the tax code that encourage consumption. In addition, it urges further study of mechanisms to increase private saving. The Council believes that investment can best be encouraged through lower interest rates and more consistent tax treatment.

INTRODUCTION

THE FISCAL-POLICY FRAMEWORK

Of the many challenges facing the United States, none is more important than adopting fiscal policies that help America compete at home and abroad. U.S. fiscal policy directly influences American economic competitiveness in several ways. First, the failure to balance the government's books causes federal budget deficits that deplete the domestic saving needed to finance investments that raise productivity and improve American living standards. Second, the allocation of federal resources determines the extent of the federal government's involvement in strengthening the "building blocks of competitiveness" — the nation's work force, its scientific and technological foundation and the public infrastructure. Finally, the structure of the tax code affects the decisions of both individuals and businesses to spend, save or invest. These elements of American fiscal policy not only create the macroeconomic environment within which firms and workers compete, they also affect the nation's overall productivity growth, which is key to rising living standards.

America's fiscal-policy problems have been driven by the failure of the nation to save enough to finance the investment in people, physical plant and equipment needed to assure the nation's competitiveness. The policies of government and the practices of individual Americans are oriented toward consumption, not saving and investment. The federal government has run a budget deficit every year, except one, since 1962. In addition, most federal spending represents income transfers or payments of net interest on growing levels of federal debt rather than investments in productivity-generating activities.

The problem of low national saving does not rest solely with the government. The personal debt of individual Americans has exploded and private saving rates are at an historic low. These phenomena are due, in part, to the public's unwillingness to live within its means, as well as to the fact that real incomes for many individuals have declined over the past decades.

This report describes the threats to the nation's competitiveness caused by America's fiscal problems. *Chapter 1* describes the emergence of those problems and highlights the consequences of the nation's inability to generate sufficient levels of saving to finance productivity-enhancing investments. The chapter focuses not only on the linkages between low national saving and declining competitiveness, but on how budget and tax policies affect investment, and ultimately, American living standards.

Chapter 2 suggests a short-term approach to overcome the immediate problem of the federal budget deficit. The Council believes that fundamental changes in current policies are required to reduce the deficit. It cannot simply be outgrown. Over the next four years, the Council recommends adopting policies that will move the nation part of the way toward reducing the deficit without using the Social Security Trust Fund surplus. After reviewing the scope of the problem, the Council recommends that no federal spending program — with the exception of those programs designed for the poor — be rejected categorically as a means to reduce the deficit. Defense, entitlements and mandatory spending and non-defense discretionary programs should all be reviewed for budget savings. Should the next President and the Congress fail to achieve deficit reduction on the spending side of the ledger alone — an objective which the Council believes will be difficult to achieve without undermining national security or abandoning the national commitment to equity — the Council urges that the door for additional revenues be left open. In *Chapter 2*, the Council presents a package of options by which the deficit could be reduced. The program seeks to achieve the three objectives of a shared contribution to deficit reduction, safeguarding the nation's historic commitment to equity, and minimizing any adverse effect on private saving and investment.

Chapter 3 outlines the three components of a longer-term agenda. Reducing the deficit is the short-term hurdle that must be cleared to place the economy on the solid foundation of saving and investment, rather than on the shaky footing of foreign indebtedness. However, three additional longer-term fiscal policy issues must be considered as part of the broader effort to reorient American thinking away from consumption and toward higher levels of saving and investment. The first component involves a recommended reordering of federal budget priorities to give greater emphasis to productivity-enhancing programs in the areas of the nation's scientific and technological foundation, human resource development and the public infrastructure. Current levels of public investment are simply not sufficient to meet critical national needs.

The second component addresses the problems caused by using the Social Security Trust Fund to mask the true size of the budget deficit. The federal government should end the practice of financing non-Social Security spending with Social Security revenues to assure the soundness of the Trust Fund. If it does not, the United States will face a crisis in just two decades that could dwarf current fiscal problems.

The third component of the longer-term agenda suggests ways that the federal government could restructure the tax code to encourage higher levels of private saving and investment. The current tax code remains biased against saving and, in some cases, rewards consumption.

The combination of short-term deficit reduction and longer-term efforts to reorient the thinking of both the federal government and individual Americans toward saving and investment will go a long way toward placing the United States on a sounder competitive footing as it approaches the next century.

CHAPTER 1

AMERICA'S FISCAL-POLICY PROBLEM

In setting the stage for a description of a pro-competitive fiscal policy, it is important to appreciate the scope and nature of the current fiscal problem and to understand how current fiscal policy affects the nation's ability to achieve the basic competitiveness objective of improved living standards.

The Worsening Problem of Low National Saving

The most compelling fiscal-policy challenge facing the United States is to reverse the decline of the national saving rate. This problem is not new; compared to many other countries, the United States has had a relatively low saving rate for most of the postwar era. However, the problem has worsened significantly in the 1980s. National saving in 1986 and 1987 was approximately 2 percent of GNP, a rate far too low to support domestic investment requirements. The current saving rate is about one-third the U.S. rate in the 1970s when supply-side concerns about inadequate saving began to surface. It is less than one-half of the saving rate of Great Britain, one-fifth the average saving rate of the major industrialized countries and one-eighth the saving rate of Japan. *Table 1* shows how the national saving rate has declined since the 1950s.

National saving is the sum of individual saving and business saving, minus the total city, state, local and federal government deficit. As such, national saving measures the domestic funds available for net national investment. Throughout the 1980s, the sum of individual and business saving and state and local government surpluses has averaged about 7.5 percent of GNP, not significantly below historical averages. What is troubling is that private saving rates have declined since the onset of the recovery from the 1982 recession. Declining state and local surpluses and a deterioration in private saving have squeezed national saving rates.

Table 1

Net National Saving Rate

1950s	7.3%
1960s	7.9%
1970s	7.1%
1980s (1980-1987)	3.0%

Source: Council on Competitiveness based on Department of Commerce data

However, the more important determinant of low national saving in the 1980s has been the surge in federal budget deficits. Although the United States has had a budget deficit almost every year since 1962 (in 1969 the nation ran a small surplus), the deficit has risen steadily — from less than 1.0 percent of GNP in the 1960s, to 2.1 percent of GNP in the 1970s, to 4.2 percent in the 1980s. This means that the federal government is siphoning off enormous amounts of private saving that could be used for productivity-enhancing investments.

Efforts to eliminate the deficit have been unsuccessful. Despite the enactment of the Gramm-Rudman-Hollings legislation, which mandates a balanced budget by FY 1993, and the 1987 Budget Summit Agreement, federal budget deficits are increasing, not decreasing. Between FY 1989 and FY 1993, the deficit, excluding Social Security Trust Fund surpluses, will increase from $199 billion to $220 billion, according to estimates by the Congressional Budget Office (CBO). It is only when the Trust Fund surpluses are included that the deficit appears to be decreasing — from $148 billion in FY 1989 down to $121 billion in FY 1993.

Figure 1 shows the difference in deficit projections when the Social Security Trust Fund is included or excluded. Even these deficit projections may be low as they assume no real growth in defense and non-defense spending and four more years of relatively steady economic growth.

The Social Security Trust Fund problem

The inclusion of the Trust Fund surpluses in the overall deficit measure poses a serious problem. The surpluses are intended to prefund the Social Security benefits of the baby-boom generation who will begin retiring next century. Under normal actuarial accounting procedures, the Trust Fund would not be in surplus, but in approximate balance.

By relying on the government's cash accounting system, however, the Trust Fund has a surplus. By using that surplus to mask the deficit run by the rest of government, the prefunding of the baby boomers' retirement is thwarted. If the Trust Fund surplus is used only to offset a corresponding deficit run by the rest of the government, when the baby boomers retire and the Trust Fund's cash surplus disappears, the overall budget will be thrown deeply into deficit. At that time, the government will face three unattractive options: taxes will have to be raised sharply, spending will have to be cut dramatically or very large government borrowing must occur. It was precisely to avoid these undesirable choices that the Greenspan Commission in 1983 recommended the prefunding solution, which was subsequently enacted into law.

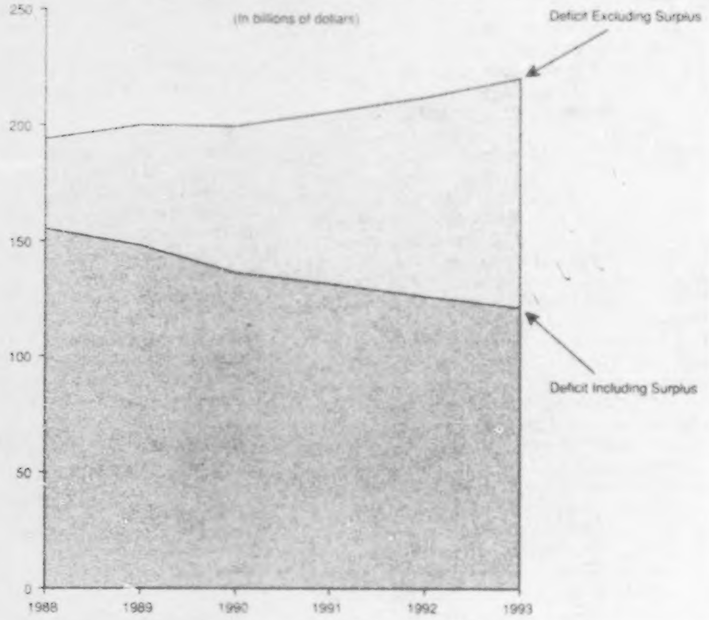
To prefund the baby boomers' Social Security commitment, the Trust Fund must be allowed to accumulate scheduled surpluses and the rest of the budget must be balanced. (*Chapter 3* includes a more complete discussion of why the Council believes that the Trust Fund surplus should be preserved.)

The Emergence of Structural Budget Deficits

The federal budget deficit arises from a shortfall in total revenues relative to total spending. There is considerable disagreement about whether the shortfall results from too much spending or too little revenue. Those arguing that spending is too high point out that total federal outlays are well above their historical levels relative to GNP — about 23 to 24 percent of GNP in the 1980s compared to 20 percent or less in the previous two decades. On the other hand, the level of total taxes relative to GNP has remained roughly equal to levels of the

FIGURE 1

PROJECTED FEDERAL BUDGET DEFICIT, WITH AND WITHOUT SOCIAL SECURITY SURPLUS



Source: Council on Competitiveness based on Congressional Budget Office data

previous decades — 18 to 19 percent — thus creating the imbalance. Those who conclude that too little revenue has caused the budget deficit argue that the rapid increase in budget deficits in 1982 and 1983 occurred as the 1981 tax cuts were taking effect, pushing revenues below what they otherwise would have been.

This debate over the cause of the deficits in the 1980s is grossly oversimplified and misleading. It fails to take into account broader economic factors, such as the major recession in the early 1980s, which affected both spending and receipts. In addition, historical levels of spending and taxation, while useful benchmarks, should not be viewed as rigid guides for current or future levels of spending and taxation.

The challenge for policymakers is to develop a clear view of the desired level of federal spending needed to accomplish future national objectives and to collect sufficient revenues to pay for these programs. Historical statistics should not be the only guide to establishing future goals. A more useful guide to both how the nation arrived at its current deficit problem and how it might extricate itself is the historical *composition* of spending and taxes.

The changing composition of outlays and revenues

Just as total federal spending as a share of GNP has increased significantly since the 1960s, the composition of federal outlays has changed dramatically. In the 1960s, spending for defense, non-defense discretionary programs and entitlements other than Social Security averaged about 15.2 percent of GNP. Social Security spending was about 2.7 percent of GNP, and net interest payments were approximately 1.3 percent of GNP. The size of the various components of the budget has changed significantly since the 1960s. In FY 1989, Social Security spending will be approximately 4.2 percent of GNP and net interest expense will be about 3.2 percent of GNP. Spending for the rest of the government (defense, non-defense discretionary and non-Social Security entitlements) will be about 14.7 percent of GNP. It is the growth in Social Security and net interest outlays that has led to the rise in total federal spending. Federal spending for other categories has actually declined as a share of GNP since the 1960s.

A similar shift can be seen in the composition of revenues. Although total revenues as a percentage of GNP have remained relatively constant over the past 30 years, these revenues are coming increasingly from social insurance receipts, which consist principally of payroll taxes (paid by both business and individuals) designed to finance the retirement benefits of current and future workers.

In the 1960s, social insurance revenues were approximately 3.7 percent of GNP, while general revenues were 14.5 percent of GNP. By FY 1989, general revenues are expected to drop to 13.7 percent of GNP, while social insurance revenues will rise to 5.1 percent. By 1993, the CBO estimates that social insurance revenues will increase to 7.1 percent of GNP, while general revenues will fall further to 12.3 percent of GNP. This trend toward increased levels of social insurance receipts — made up mostly of Social Security collections — relative to Social Security outlays simply reflects the prefunding of the Social Security Trust Fund to pay for the baby boomers' retirement. Nevertheless, general receipts are lagging well behind federal spending for programs other than Social Security.

At a minimum, this review of the changing composition of outlays and revenues clarifies several key issues. First, one of the fastest-rising outlays (net interest) cannot be controlled directly; interest due on the national debt must be paid. Of course, as the deficit is reduced, increases in the debt burden and net interest payments will be slowed down. Second, Social Security outlays have increased significantly — due both to the growing number of retirees and to more generous benefit payments. Third, spending for non-Social Security programs — specifically for defense and non-defense discretionary programs — has fallen, but the taxes to pay for these remaining outlays have fallen even more. Has spending for these programs been reduced enough? Are additional cuts needed? Are additional revenues needed? Should Social Security benefits be cut and a portion of Social Security taxes replaced with general revenues to fund non-Social Security spending? These are the critical questions that must be addressed in designing a pro-competitive fiscal policy.

The Budget Deficit and Declining Competitiveness

Since large federal deficits emerged in the early 1980s, various predictions have been offered about the effect of those deficits on the economy. A number of analysts have argued that deficits might be helpful — in that they stimulated spending — or would have little effect on the nation's overall economic health. Others predicted that deficits would harm the economy and that the effect would be immediate: either through rapid inflation or the abrupt termination of the recovery from the 1982 recession. The truth lies somewhere in between. The federal budget deficits have indeed harmed the economy; the consequences are far-reaching and will continue well after the budget deficits are eliminated. The impact, however, has been less immediately apparent than the gloomiest predictions forecast, as the six years of comparatively low inflationary growth America has enjoyed attest.

Tax financing versus deficit financing

To understand the effect of the budget deficit, one must first recognize that deficits (or government borrowing) are simply one method of financing government spending. The choice between how spending is financed — either through increased revenues to meet spending requirements or through deficits — does not alter the direct burden of the government on the private sector. For example, if the government spends $1 trillion, the private sector (individuals and corporations) must finance that $1 trillion. If only a portion of that spending is financed through taxes and the remainder through deficit financing, the private sector still bears the entire burden; the burden is only more indirect.

The way that taxes finance government spending is straightforward. Higher taxes — be they income, consumption-related or business taxes — reduce the disposable income that individuals and companies have for both consumption and saving. The reduction in purchases by the private sector, however, is offset by the government's expenditure of the tax proceeds, most of which goes for consumption. In essence, individuals and companies, through their reduced purchases of consumable products and capital goods investments, pay for the government's purchases.

Deficit financing, on the other hand, has the identical effect of financing federal spending, but its effect on the private sector is quite different. Government borrowing directly affects the total levels of private saving available to purchase investment goods, but it has little or no effect on consumption.

As simple as this point may be, it is absolutely crucial. For a given level of government spending, the total direct burden on the private sector — in the sense of the total reduction in purchases of consumable goods and investment in capital goods — is the same. However, financing government spending through higher taxes — depending upon the tax structure selected — spreads the burden between consumption and investment. Deficit finance, however, affects mostly investment — by diverting private saving from the purchase of capital goods to government purchases. Given the competitiveness objective of moving from consumption toward saving and investment as a way to promote greater productivity and higher living standards, financing federal spending through increased taxes has less of a direct adverse effect on domestic investment.

Foreign capital inflows have reduced the burden of deficit finance somewhat by enabling investment levels to be higher than domestic saving levels. However, there are significant costs associated with a reliance on foreign capital caused by budget deficits that reduce domestic saving rates to levels too low to support domestic investment needs. This issue is discussed later in this chapter.

Deficit finance, investment and productivity

The traditional analysis of the effects of deficits is that a decline in net national saving will lead to a comparable decline in net investment. *Table 2* shows the relationship.

Table 2

Net Saving and Investment Rates, 1950s-1980s

	Net National Saving Rate	Net Domestic Investment Rate
1950s	7.3%	7.4%
1960s	7.9%	7.2%
1970s	7.1%	6.9%
1980-1987	3.0%	4.8%

Source: Council on Competitiveness based on Department of Commerce data

The decline in investment in the 1980s is not quite as steep as the decline in saving — thanks largely to inflows of foreign capital — but it is dramatic. An investment rate of only 4.8 percent of GNP is approximately 2.4 percentage points below the average of the previous three decades. Worse, the current rate must be interpreted in light of the widespread conclusion that U.S. investment during the postwar period was too low to begin with, particularly compared to the investment rates of America's major trading partners. In 1980, it was agreed that the United States must invest more. Tragically, America has cut its investment rate by one-third instead.

The investment rate has fallen so dramatically for one principal reason: the nation has chosen to finance a large share of federal spending not through taxes, which primarily reduce consumption, but by deficits that divert saving from financing investments and drive up interest rates. Simply put, when the public sector soaks up a large share of private saving, there is less available for domestic investment. Not surprisingly, investment falls.

What are the implications of lower levels of investment for U.S. competitiveness? Levels of investment are the key determinant of increased productivity and subsequently of good, high-paying jobs and higher living standards. While U.S. productivity has remained fairly steady since the 1970s in absolute terms, in relative terms the nation has lost considerable ground in the race to raise productivity. Largely because of higher levels of investment, the nation's foreign competitors have experienced stunning productivity advances that have enabled them to rapidly increase living standards. Some economists have estimated that for the United States to maintain its living standards, given the changing demographics, net national investment will have to almost double — to 8 percent of GNP. This will require dramatically higher levels of domestic saving or, alternatively, even greater dependence upon foreign capital inflows.

Low saving levels and the trade deficit

Much of the concern over U.S. competitiveness has been triggered by the record trade deficits of the 1980s. In fact, the more significant threat to U.S. competitiveness results from the decline in investment. As noted above, that decline implies less capital per worker, slower productivity growth and less growth in per-capita incomes than would occur with more investment. Ironically, the trade deficit actually mitigates the decline in investment. As disconcerting as it seems, until the budget deficit is reduced radically and national saving is increased, continued large capital inflows — and their counterpart current account deficits — will be needed to prevent a further decline in domestic investment.

Table 3 repeats the net saving and investment rates shown in *Table 2*, along with the net foreign investment flows into the United States as a percent of GNP.

The by-product of low national saving, and the tight monetary policy that has been required to offset the massive fiscal stimulus, has been low levels of investment. High interest rates associated with tight monetary policy have had two other effects: they contributed to the strengthening of the dollar in the early 1980s and attracted foreign capital. This latter phenomenon is the reason that U.S. domestic investment has not fallen as low as domestic saving. Rather than limit domestic investment to the low levels of national saving, America has borrowed from abroad. Even though the investment financed through foreign saving is owned — directly or indirectly — by foreigners, that investment can add to productivity increases and to overall economic growth.

Foreign capital inflows that result from extremely low saving rates, however, are a mixed

Table 3

Net Saving, Investment and Foreign Capital Inflow Rates (as a percent of GNP)

	Net National Saving Rate	Net Domestic Investment Rate	Net Flows of Foreign Investment
1950s	7.3%	7.4%	——
1960s	7.9%	7.2%	-0.7%
1970s	7.1%	6.9%	-0.2%
1980-1987	3.0%	4.8%	1.8%

Source: Council on Competitiveness based on Department of Commerce data

Table 4

The Saving-Investment Gap and Current Account Deficit (in billions of dollars)

	Gap Between Domestic Saving and Net Domestic Investment*	Net Foreign Investment	Current Account Deficit*
1980	13	-13	3
1981	11	-11	7
1982	-1	1	-9
1983	-34	34	-46
1984	-91	91	-107
1985	-116	116	-116
1986	-144	144	-141
1987	-156	155	-162

* Difference between the saving-investment gap and the current account deficit is a statistical discrepancy

Source: Council on Competitiveness based on Department of Commerce data

blessing for two reasons. First, the repayment of principal and interest on growing levels of foreign debt directly reduces future living standards. Just repaying the foreign debt incurred in 1987 alone, exclusive of interest, will require each family of four to pay $2,600. Second, as *Table 4* shows, the growing saving-investment gap, which has been satisfied by foreign capital inflows, is the mirror image of growing current-account deficits. Record current account deficits in the early 1980s arose in part through interest rate adjustments that attracted foreign capital, and until 1985, drove up the value of the dollar.

Trade deficits are also the result of the effect of foreign capital on consumption in the economy. Between 1982 and 1987, domestic consumption in the United States as a percentage of GNP was one full percentage point higher than domestic production — largely as a result of foreign capital inflows, which stimulated domestic spending. In turn, a record volume of foreign goods and services was needed to satisfy U.S. demand which exceeded U.S. production.

This is the key competitiveness dilemma for the United States. Without foreign capital inflows, U.S. investment would fall even further — down to the depressed levels of national saving. Using net foreign investment to reduce the gap between saving and investment, however, requires that the large current account deficits be sustained. Phrased another way, in order to borrow at this rate, our lenders must be able to run a trade surplus with us.

Any reduction in the trade deficit that is not accompanied by an increase in national saving must be accompanied by a fall in domestic investment, thereby worsening America's fundamental competitiveness. Ironically, a deterioration in the trade deficit means that foreign capital inflows are increasing, which signals that at least the United States has access to investment funds. Unfortunately, in recent years, a significant portion of foreign capital that flowed into the United States has simply helped finance the gap between public consumption and revenues, rather than productive investments, which has not enhanced the country's ability to repay foreign debt.

The solution to this dilemma, however, and the principal means of improving U.S. competitiveness, is to reduce the federal budget deficit. By doing so, and thereby increasing levels of national saving, America will be able to finance by its own means more of its domestic investment. Ideally, America would continue to attract foreign capital, but foreign funds would be lured by productive investment opportunities in the American economy. In other words, improving domestic saving rates would facilitate a return to higher levels of investment that could be financed without capital inflows. Of course, foreign capital would remain desirable since it would facilitate a greater expansion of America's physical plant.

Competitiveness and the Structure of Spending and Tax Systems

Government fiscal policies influence the national saving rate, the value of the dollar and the trade deficit. Furthermore, the ways in which the federal government allocates resources and raises revenues have a profound effect on productivity, economic growth and competitiveness.

The federal budget and U.S. competitiveness

The nature, scope and priorities of spending significantly affect the degree of federal involvement in productivity-enhancing programs that underpin the nation's long-term competitiveness. Programs to buttress the nation's scientific and technological base, to strengthen the capabilities of the work force and to ensure the soundness of the nation's infrastructure are the "building blocks" of American competitiveness and future living standards. In each area, the United States faces major challenges.

Science and technology. America must effectively develop and deploy technology to remain competitive in the global market. Technology has long been a key element of the nation's ability to compete while maintaining a high standard of living. Leading economists argue that technology is directly or indirectly responsible for as much as two-thirds of the productivity growth the United States has enjoyed since the Depression.

The federal government makes a significant contribution to America's scientific and technological development by establishing and maintaining the infrastructure for science and technology, providing support for science and math education, financing university research facilities and underwriting R&D projects in the universities.

Although total federal R&D support has increased by almost 100 percent during the past seven years, 90 percent of this increase has been for defense-related R&D. As a result, real federal support for civilian R&D in FY 1988 is 14 percent below the FY 1980 level. In real terms, funding of the National Science Foundation (NSF) has remained essentially unchanged over the past 20 years. Within the NSF budget, funding for the Education Directorate, which includes support for graduate education as well as elementary and secondary teacher-enrichment programs in the science and math disciplines, is at the same level today as in the early 1980s.

In the 1980s, federal non-defense funding for university research plant and facilities has declined 95 percent in real terms. In a 1986 study on the health of U.S. colleges and universities, the White House Science Council estimated that a $10-billion program over the next 10 years would be required to bring university research facilities up to an adequate level.

To remedy these deficiencies, greater attention and funding must be given to developing the infrastructure — both human and physical — to sustain America's leadership position in science and technology.

Human resource development. Development of America's human resources is a prerequisite of increased competitiveness. America now operates in a global economy characterized by the internationalization of all aspects of production. Within such an environment, the access of firms to a high-quality labor pool will help determine in which countries basic and applied research takes place, in which countries technological advances are most rapidly commercialized and in which countries production facilities are located.

The federal government has a circumscribed but important role in human resource development — primarily through programs to address the needs of the educationally and economically disadvantaged. Unfortunately, funding levels have not been adequate to serve the eligible populations. During the 1980s, in spite of expanding populations for federal programs, funding for a variety of programs established to address these problems has declined in real terms.

Infrastructure. America's infrastructure — which includes its bridges, roads, dams, airports and waterways — underpins the economy and is a key element in the nation's future economic development. Unfortunately, America's infrastructure is deteriorating faster than it is being replaced. The consequences of this trend could be reduced productivity in key economic sectors, a lower Gross National Product, increased consumer prices and reduced personal income.

The tax code

As noted previously, the federal deficit does not bear the entire responsibility for the decline in national saving. Saving by the rest of the economy — corporate, individual and state and local governments — has also fallen despite the apparent strength of the economic recovery. Net saving by individuals and corporations fell to less than 5 percent of GNP in 1987, from long-term averages of more than 7 percent. From 1984 to 1987, a substantial drop in the federal deficit lowered federal dissaving from 4.8 percent to 3.4 percent of GNP. But the national saving rate scarcely improved because saving by the rest of the economy declined, from 6.6 percent to 5.3 percent of GNP.

The structure of the tax code influences individual and corporate decisions to spend, save and invest. The existing code is a mix of levies against income and consumption. Income taxes consist of the payments corporations and individuals make on gross earnings. In addition, taxes are collected for various types of consumption, such as gasoline, tobacco and alcohol. Many economists have argued that the current mix, by emphasizing taxes on income, discourages saving. Although the relationship between taxes and saving is not well understood, one fact is clear: the structure of the tax code does little to encourage saving, although increased levels of private saving are desirable and necessary. (See *Chapter 3* for a more detailed discussion.)

The preceding analysis demonstrates how the fiscal policies that have guided the American economy for a number of years have compromised efforts to maintain and enhance American competitiveness. How fiscal policy can be better structured to support competitiveness goals is the subject of the following chapters.

CHAPTER 2

A SHORT-TERM DEFICIT-REDUCTION PACKAGE

As one of the major causes of low levels of saving, the federal budget deficit is among the primary obstacles to higher living standards for future generations of Americans. It also has undermined the nation's ability to advance its economic, foreign-policy and national-security agendas abroad. A decline in private saving also has contributed to the problem of low national saving, but the motivations for private saving are less well-known and the effects of measures designed to induce private saving uncertain. Deficit reduction, on the other hand, produces a known result — increased national saving. Lying beyond the deficit hurdle is the prospect of an economy resting on the solid foundations of saving and investment rather than on the shaky footing of foreign indebtedness.

Reducing the deficit will not be easy. Although there are many ways to reduce the deficit, none is attractive politically. Congress and the President have attempted to rein in the deficit, but many options have been foreclosed and tough decisions avoided. The circumscribed efforts of policymakers have shown that deficit reduction cannot be accomplished through asset sales or user fees, by delaying a weapons system here or cutting a foreign aid program there, or by assuming increased economic growth. Nothing less than a genuine, all-out commitment to reduce the deficit — which must include slowing the growth in federal spending — will complete the task.

The Council appreciates that President-elect Bush has expressed serious concern about the need to reduce the budget deficit. The Council believes that the new President should be afforded an opportunity, working with the Congress, to develop a program. The window of opportunity is narrow, however, and the Council urges the next President to move quickly to design and implement his program. The pro-competitive deficit-reduction package described below, which represents one way in which to reduce the deficit, is designed to help in this difficult task.

Guiding Principles

The Council believes that the success of any deficit-reduction effort requires meshing three basic principles. First, all sectors should contribute to the deficit-reduction initiative. Second, changes should be fair; they should not undermine the nation's historic commitment to equity. Third, attempts should be made to ensure that changes in either budget or tax policy increase economic efficiency and minimize any adverse impact on levels of private saving and investment.

In some instances, there may be tension among these three principles — and not all can be simultaneously and perfectly achieved. For example, instituting measures to increase business investment may be useful from a competitiveness perspective, but almost certainly will require selective tax reductions or incentives for people or corporations with funds to invest. This shifts the cost of investment to other parts of the economy, thereby raising the cost of capital generally. In addition, such measures may result in a net decrease in national saving. Similarly, large portions of federal spending have little to do with improving the nation's competitiveness, but are important for other reasons. Nonetheless, the Council believes that potential conflicts can be reasonably reconciled through a balanced deficit-reduction package that does not rely excessively on any single program or tool to close the budget gap.

A Deficit-Reduction Target

The Council recommends that a minimally adequate short-term goal for the next Administration would be to reduce the deficit by an additional $30 billion annually in each of the next four years. Reductions would total $120 billion in FY 1993, bringing the nation part of the way toward reducing the federal budget deficit by then. (For an extended discussion of how the Council believes the Trust Fund should be treated over the longer term, see *Chapter 3*.)

U.S. success in bringing down the value of the dollar from its record high in the mid-1980s has opened up a unique opportunity for a successful transition to a pro-competitive fiscal policy without undermining overall economic demand. The proposed $30-billion reduction in the deficit matches the rate of improvement now taking place in the U.S. trade balance. This new demand for exports can substitute against the demand previously provided by the larger federal deficit, thus reducing the possibility of a recession that might otherwise occur from reductions in the federal budget deficit. The $30 billion is also the amount of new capacity that could be brought on-line in export- and import-competing industries.

Thus, deficit reduction must be accompanied by related policies that foster rapid improvements in the trade deficit and high levels of investment in new capacity. As pressure on financial markets is reduced through credible deficit reduction, the Federal Reserve Board must allow real interest rates to decline, facilitating more rapid business investment and making it easier to manage further declines in the dollar's value and steady improvements in the trade deficit. The achievement of these interrelated goals is key to achieving a high-growth transition to a more competitive economy.

Spending

Understanding the options

Successful deficit reduction depends upon controlling the growth of federal spending. As noted in *Chapter 1*, federal outlays as a proportion of GNP have increased significantly during the 1980s, from an average of 20 percent of GNP throughout the 1970s to an average of 23 to 24 percent of GNP in this decade. The CBO projects that spending will decline by FY 1993 to more normal historical rates of slightly more than 21 percent of GNP. However, the CBO assumption is based on no real growth in either the defense or non-defense discretionary portions of the budget and it foresees no substantial slowdown in the economy. A recession or an interest-rate boost could send spending levels higher, as would approval of new domestic spending for such programs as education, AIDS research, housing or the savings and loan bailout, which is now estimated to cost $50 billion to $100 billion. But more importantly, even at CBO's estimated growth levels, the deficit will remain quite large during the next decade.

The Council believes that, with one exception, all programs must be reviewed for possible saving. Given recent declines in funding for means-tested programs and the nation's commitment to the poor, the Council believes that these programs should not be included in the deficit-reduction [illegible]rt. In recent years, deficit-reduction efforts [illegible] exempted certain programs from cuts, and budget [illegible] have fallen disproportionately in two areas: defense and non-defense discretionary spending. After several years of rapid growth, budget authority for defense has been reduced in real terms for four consecutive years. In real terms, non-defense discretionary spending in FY 1989 remains below FY 1981 levels. But the entitlement and interest portions of the budget have continued to grow.

These near-term shifts in federal spending reflect longer-term structural changes in the composition of federal spending. Over the past several decades, spending for defense and non-defense discretionary programs as a percentage of total federal spending has dropped substantially — from nearly two-thirds of all federal outlays in the early 1960s to just over 40 percent by the early 1980s. The downward slide is projected to continue under the CBO's projections of no real growth in either portion of the budget. *Figure 2* shows program shares of the federal budget from FY 1962 to FY 1993.

Defense spending dropped dramatically from FY 1962 to FY 1972, with the defense share of the budget declining even more rapidly upon conclusion of the Vietnam War. Over the past decade, defense spending has remained roughly constant as a share of total federal spending, despite the defense build-up of the early 1980s.

Non-defense discretionary spending fell as a proportion of the federal budget after FY 1982. If spending growth just adheres to projected inflation through FY 1993, non-defense discretionary spending will fall further to approximately 14 percent of the budget, about the same amount paid out to service the debt.

Indeed, interest payments as a share of all federal spending have doubled as a result of the large deficits and high interest rates of the 1980s. By FY 1993, nearly an equal amount of federal spending will be directed toward paying for past borrowing as will be spent on programs in the non-defense discretionary portion of the budget, which includes AIDS research, the Space Shuttle program and most education programs.

Throughout the past two decades, entitlement spending has grown more rapidly than other programs. Entitlement spending increased substantially from FY 1962 to FY 1972, from 28 percent to 39 percent of the budget, and had increased by FY 1982 to 46 percent of outlays. It is expected to increase modestly to 47 percent of federal outlays by FY 1993.

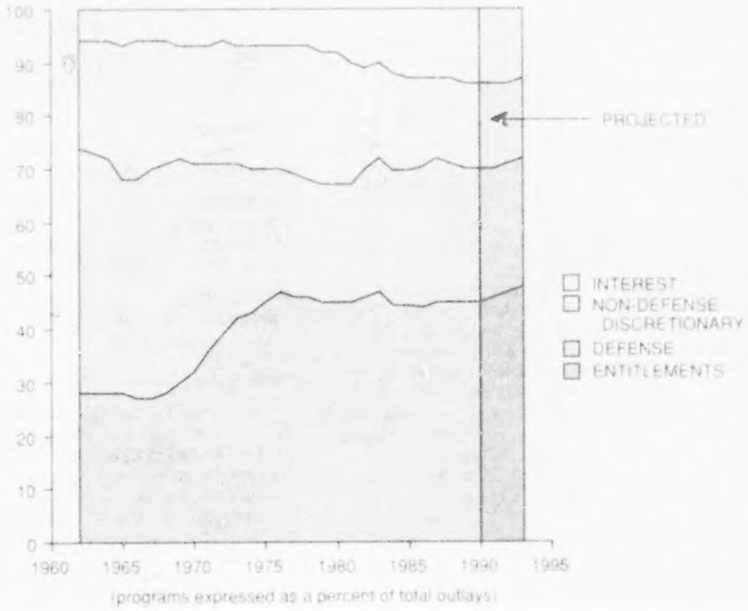
Significantly, during the 1980s, defense and non-defense discretionary spending have been turned to frequently for budget savings. On the other hand, entitlement spending often has been exempted from deficit-reduction efforts, although it accounts for a greater share of federal spending than defense and non-defense discretionary spending combined.

Under CBO estimates, entitlement spending is projected to grow over the next four years, while defense and non-defense discretionary spending are assumed to keep pace with inflation. Within entitlement accounts, farm subsidies are anticipated to continue declining as the farm economy regains its strength. Most of the spending growth is anticipated in Medicare and Social Security programs, which are expected to grow 11 percent and 6 percent, respectively, each year through FY 1993.

Because of the changing composition of federal spending and the projected growth in Social Security and Medicare, the Council believes that all spending programs must be reviewed for possible savings. It stretches plausibility to believe that an annual deficit-reduction target of $30 billion can be achieved by reducing spending growth in programs that account for only 40 percent of federal spending. Including programs such as Social Security and Medicare in a deficit-reduction effort does not imply that benefits would be cut wholesale or that vital income and health support would be denied. Judicious program changes can ensure that the much-needed benefits for low-income elderly are retained, while those most able to pay will contribute to reducing the deficit. The Council hopes that all beneficiaries of government programs will be willing to make modest sacrifices if the rationale for changes is compelling and if it is clear that special exemptions and favors are not granted to groups that are able to contribute.

FIGURE 2

OUTLAYS BY CATEGORY: 1962-1993



Source: Council on Competitiveness based on Congressional Budget Office data

Spending caps: a tactic for controlling spending

The Budget Summit Agreement of November 1987 demonstrated convincingly that spending caps are an effective method of controlling the growth in federal spending. The premise underlying a spending cap is simple: Congress and the President agree on a certain level of spending for a portion of the budget, such as defense, and adhere to that amount. Changes can be made to individual programs, as long as the total of all programs does not exceed the cap. An increase in one program must be offset by a decrease in another to stay within the ceiling.

Spending caps reflect a different approach to reducing the deficit. In the past, policymakers have established a dollar goal for deficit reduction. For example, if Congress projects a deficit of $150 billion in a given fiscal year and attempts to cut $35 billion from that figure, an economic change that caused the deficit to increase to $200 billion would mean that the deficit would still be $165 billion after cuts were made.

The Council has recommended a broad goal for deficit reduction of $30 billion per year. But the Council also recommends caps to make the process of controlling spending fail-safe. By setting spending caps, policymakers agree that outlays will not exceed a preset level, despite underlying economic changes. If the economy grows faster than anticipated, the deficit is reduced more quickly; if the economy slows down, spending reductions are not delayed.

The Council has developed an illustrative set of spending caps that meet its objective of reducing spending growth in defense, entitlement programs and non-defense discretionary spending (see *Table 5*). Within each cap, the Council has advanced program changes that meet its tests of equity and increased efficiency in public spending. Each area of the budget is reduced by roughly the same amount — 3.7 percent from the FY 1993 CBO baseline — consistent with the principle of shared sacrifice. The baseline is the estimate of what the federal budget deficit will be absent further policy changes.

Clearly, there are program changes that could reduce spending other than those presented below, but the Council believes that the spending-caps mechanism is sound and should be utilized. The spending levels suggested below may not be the ones adopted by the President and the Congress. Whatever levels are established, those levels should be agreed to in legislation and the total of program expenditures should not exceed the agreed-upon caps. This procedure worked in the Budget Summit and it should be put to work again.

Options for Reducing Spending Growth

The following review of federal spending programs suggests possible program changes that could save money and thereby reduce the deficit. There are numerous ways to reduce the deficit. Nevertheless, the maximum amount of annual spending reductions that the Council believes can be made, given the need to enhance the nation's competitiveness, is approximately $48 billion by FY 1993 (excluding interest savings). In adopting spending priorities, the Council believes that policymakers should ensure that the changes will either be progressive or lead to more efficient allocation of scarce public resources. The changes are discussed within the context of caps on outlays for each broad budget area.

Table 5

Spending Caps for Major Budget Categories
(in billions of dollars)

	FY 1990	FY 1991	FY 1992	FY 1993
Defense				
CBO Baseline	310	322	335	348
Council Plan	307	316	325	335
Entitlements				
CBO Baseline	573	614	656	702
Council Plan	567	598	636	676
Non-Defense Discretionary				
CBO Baseline	204	208	172	223
Council Plan	202	203	210	214
Total Spending Reductions	11	27	37	48

National defense

Proposed spending caps: $307 billion in FY 1990, $316 billion in FY 1991, $325 billion in FY 1992 and $335 billion in FY 1993.

Defense spending is the largest portion of the federal budget controlled through the appropriations process. In FY 1989, budget authority for defense is $299 billion, with outlays projected at $294 billion.

From FY 1981 to FY 1985, the budget for national defense grew dramatically: budget authority increased at a real annual rate of more than 9 percent. Real defense outlays increased by 5.8 percent per year from FY 1980 to FY 1987, considerably above the rate of inflation. Real outlays will fall for the second consecutive year in FY 1989, but will still be 47 percent higher than in FY 1980. In setting levels of defense spending, policymakers will have to address four key issues.

- **Issue 1: Authority vs. outlays.** Each year, Congress approves a level of defense budget authority that is transformed into outlays. Outlays, which affect the size of the deficit, are produced at varying rates for different defense programs. Budget authority for an aircraft carrier would result in seven or more years of outlays, while authority for salaries is generally spent in the year it is approved.

Because outlays are determined on the basis of a combination of commitments made in both the current fiscal year and prior fiscal years, a certain amount of defense spending is not subject to control. Contracts made in earlier years must be fulfilled, which entails spending money already appropriated and obligated. In FY 1989, for instance, 40 percent of defense spending will fulfill prior-year obligations. Thus, most of the short-term cuts in defense will tend to fall in the 60 percent of the budget that is controllable — pay and benefits, some research and development and procurement programs. For this reason, a one-year freeze in defense spending would be hard for the Defense Department to absorb.

- **Issue 2: The plans-reality gap.** Throughout the 1980s, DoD planners developed internal program schedules as if the large increases in authority characteristic of the early 1980s would be sustained indefinitely. This plans-reality gap was the outgrowth of the inability of Congress and the Executive Branch to agree on a program of defense spending. Although annual appropriations were inevitably lower than expectations, budget plans did not adjust to tighter fiscal restraints.

  Because this practice occurred for several years, internal defense plans are now far out of balance with fiscal realities. For example, the five-year defense plan developed by the Pentagon for FY 1989 to FY 1993 was based on anticipated funding of $1.9 trillion over the period. The Administration, however, submitted a budget plan for the same period that called for $1.6 trillion in combined funding. Even that level is likely to be far above the spending that is approved. DoD officials are now cutting weapons and troops to conform to lower-than-expected spending. Meeting lower spending plans will require further difficult adjustments.

- **Issue 3: The strategic context for adjusting spending.** Defense spending levels in recent years have been established within the context of the government's fiscal crisis. Because of continued large deficits, Congress has made many cuts in the Administration's military-development plan. Although complaints frequently have been voiced that cuts have interfered with the proper development of the nation's armed forces, fiscal necessity has induced reductions in spending.

  Ideally, defense spending levels should be tied to the overall strategic plan for the nation. However, defense development must also be mindful of the limited resources available. Although the Council's defense-spending recommendation is based on its judgment of what the nation can afford, given the need for deficit reduction and shared sacrifice, the Council has not sought to take the next step, that of preparing a detailed military-development plan. That role belongs appropriately to the President and Congress. Working together, the Administration and Congress should develop a strategic plan founded on the near-term reality of a difficult fiscal environment.

- **Issue 4: Increased future funding to implement weapons-reduction agreements.** Negotiations with the Soviet Union recently yielded a treaty to eliminate intermediate-range nuclear weapons. Verifying compliance with the agreement and developing conventional forces to offset any imbalances that emerge after nuclear forces are reduced could prompt spending increases for certain types of military forces, particularly conventional forces.

Although each of these four problems reveals some difficulties and potential pitfalls attending defense cuts, they are overshadowed by the broader issue that a defense spending cap and a strong effective national defense program are not mutually incompatible objectives. This is particularly the case if spending growth is reduced through persistent efforts to develop national-security strategies and the increased efficiencies discussed below.

Most promising spending-reduction options. Significant savings may be realized through persistent efforts to improve efficiency in all facets of defense management. For example, the procurement reforms recommended by the President's Blue Ribbon Commission on Defense Management (Packard Commission) could be more broadly implemented. The Commission called for streamlining defense-acquisition practices and overhauling management practices to achieve greater efficiency in weapons development and procurement.

Suggested administrative means to achieve greater economies in purchasing include:

- greater reliance on multi-year procurement;
- expanded purchase of "off-the-shelf" technologies;
- streamlined acquisition procedures, including shorter lines of authority and less red tape associated with each procurement program;
- simplified acquisition statutes.

Implementing the recommendations of the Packard Commission and undertaking other efforts to reduce administrative and management costs will require undoing many past procurement practices. Over the years, the complexity of procurement procedure has increased substantially, greatly lengthening the time from weapons conceptualization to production. Eliminating bureaucratic requirements — rules often put in place ostensibly to prevent cost overruns or overcharges — could actually reduce costs and assure more timely development.

In addition, weapons often are produced inefficiently, adding costs. In a 1987 study, for instance, the CBO concluded that weapons-procurement stretch-outs added an average of $4 billion per year to total acquisition costs between 1981 and 1984. Of the 40 weapons systems studied, only half were produced at the projected lowest cost estimates between 1983 and 1987.

Many procurement reforms offer potential savings. When programs are approved, application of multi-year procurement guidelines could reduce unit costs, thus lowering overall program costs. For example, in a separate study the CBO estimated in 1986 that increasing multi-year procurement from its existing level to 15 percent of acquisition authority would save $6.8 billion over a four-year period.

Eliminating redundancies or unneeded resources may also lower national defense costs, yielding additional savings that can be used to reduce the deficit. The Defense Department controls large amounts of land and facilities, not all of them required. Closing certain bases could produce annual budget savings without impeding national defense requirements. Recent legislation related to base closings projects savings of $2 billion to $5 billion per year. Removing unnecessary forces could also yield cost reductions. The CBO estimates, for instance, that eliminating the forces and indirect personnel still stationed in Europe to operate intermediate-range nuclear weapons could save more than $1 billion per year.

The role of Congress. Economizing on defense expenditures is not the sole responsibility of the DoD. Many inefficiencies in procurement and management are created by excessive congressional control of administrative and acquisition practices. If the Defense Department is to achieve savings through productivity gains, Congress must become a full partner in the effort.

Specific practices that should be avoided include micro-management of the defense budget, duplicative committee review and purchases of unneeded weapons that are manufactured in a particular legislator's district. When defense spending is already being squeezed, the country cannot afford excessive administrative costs. Nor can it afford programs that add little to the national defense, but are undertaken to satisfy the desires of Members of Congress for hometown production or military bases.

The benefits of consistency. If the Council's proposal to reduce defense spending by establishing caps is agreed to and supported by strong enforcement measures, the need to improve efficiency will be considerably eased. The annual defense budget often varies substantially from year to year and from DoD projections. Establishing and maintaining a long-term spending plan will reduce the fits and starts of defense funding, thus facilitating planning and implementation. The Packard Commission noted that large fluctuations in defense spending add costs while providing less defense. A four-year spending cap, accepted in advance and adhered to, can help provide the impetus needed to rationalize the defense budgeting process to reduce existing inefficiencies.

Entitlements and other mandatory spending

Proposed Spending Caps. $567 billion in FY 1990, $598 billion in FY 1991, $636 billion in FY 1992 and $676 billion in FY 1993.

Entitlements and other mandatory spending represent the largest single category of federal spending, accounting for $536 billion, or approximately 47 percent of the total federal budget in FY 1989. Furthermore, spending is projected to increase substantially faster than inflation between FY 1989 and FY 1993. The greatest increases are projected in Medicare and Social Security programs.

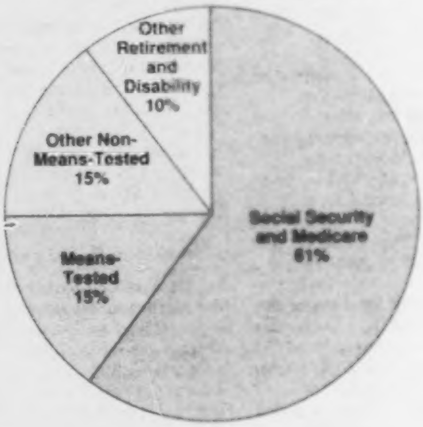
Entitlement programs provide benefits to all individuals who qualify and decide to receive such support. Unlike other federal programs, where funding levels are determined in the annual appropriations process, entitlement spending levels are determined by eligibility rules and participation. Thus, to curtail the growth of entitlement programs, Congress must modify the laws governing eligibility, benefits or reimbursement of service providers.

There are four major entitlement categories. Each category's share of the total entitlement budget is shown in *Figure 3*.

The program changes discussed below are illustrative of the types of policy options the Council believes should be considered to meet the overall spending cap for this category.

FIGURE 3

ENTITLEMENT SPENDING BY CATEGORY, 1986



Source: Council on Competitiveness based on Congressional Budget Office data

- **Non-means-tested programs** provide benefits regardless of income. The major programs in this sector include Social Security and Medicare.

- **Means-tested programs** provide benefits subject to an individual meeting income-eligibility requirements. These programs include Medicaid, food stamps, Supplemental Security Income, family-support payments and child nutrition.

- **Other programs** include an array of entitlements, such as farm-price supports, veterans' service-connected compensation, social services and unemployment compensation.

- **Retirement and disability programs** provide benefits to former civil service, military and railroad employees.

Non-means-tested programs: Social Security

Option: Increase taxes on benefits of higher-income Social Security recipients. Social Security payments constitute the largest component of the entitlement account, with projected outlays of approximately $234 billion in FY 1989. Social Security costs are projected to increase at an annual rate of approximately 6 percent through FY 1993, bringing Social Security payments up to an estimated $300 billion annually.

The 1987 Budget Summit Agreement and Gramm-Rudman-Hollings legislation both exempted Social Security from the deficit-reduction effort. Indeed, Social Security recipients have received extra payments beyond what is stipulated in benefit-increase procedures. In January 1988, Social Security beneficiaries received a cost-of-living adjustment (COLA), even though the rise in the Consumer Price Index (CPI) was not sufficient to generate the adjustment automatically.

Social Security provides vital income support to the nation's elderly. However, because of the program's size, excluding it from the deficit-reduction package would require disproportionate cuts in other areas of the budget. Some argue against tampering with Social Security by pointing out that the Social Security Trust Fund is operating at a large surplus, which is expected to increase to approximately $99 billion in FY 1993. In addition, Social Security taxes paid by workers have increased to 7.51 percent of wages.

However, the surplus is intended to finance the benefits of future retirees (see *Chapter 3* for a more extended discussion of the Social Security Trust Fund over the longer term). Moreover, if the burden of Social Security reductions can be equitably placed only on those who truly can afford to make a modest sacrifice, Social Security should be included in a short-term deficit-reduction package.

The Council believes that fairness and savings can be achieved by increasing taxes on benefits of higher-income Social Security recipients. Under current law, only half of Social Security benefits are taxed over a threshold amount — $25,000 for single returns and $32,000 for joint returns. An individual whose annual income is $24,000 pays no taxes on his or her Social Security benefits. Even an individual who earns more than $25,000 pays taxes on only half of the benefits.

The Council suggests that the existing floor for the taxation of benefits be lowered. Reducing the threshold to $18,000 for a single filer and $25,000 for a joint return would ensure that lower-income beneficiaries are not affected by this change.

The Council also suggests that the percentage of benefits taxed increase from 50 to 85 percent. Economists estimate that, for an average beneficiary over his or her lifetime, 85 percent of Social Security benefits represent income transfer from the government and only 15 percent represent what was actually contributed by the beneficiary. Thus, for most beneficiaries, taxing up to 85 percent of benefits still avoids double taxation. This ratio may change in the future as a result of the recent payroll tax increases. If it does, the Council would support recalculating the income-transfer portion of benefits to ensure that benefits are not taxed a second time. As important, reducing the thresholds and increasing the percentage of benefits taxed would make the tax treatment of Social Security benefits more comparable to the tax treatment of private pensions. Adopting these two changes would reduce Social Security program costs by $9 billion in FY 1993. Consistent with the 1983 changes to Social Security mandated by Congress, increased receipts from this proposal would go to the Social Security Trust Fund.

Non-means-tested programs: Medicare

Option: Control the rate of increased costs for Medicare. Medicare is the third largest program in the federal budget — and the fastest-growing, despite measures previously enacted to control program costs. It has grown by an amount equal to 1 percent of GNP every 10 years since it was established. Between FY 1989 and FY 1993, spending for Medicare is estimated to increase 11 percent annually. The reasons behind these skyrocketing costs are a growing universe of eligible enrollees, high utilization rates of expensive medical procedures and medical price increases about twice the general inflation rate.

Medicare has two components. Part A provides hospital-based services to beneficiaries and is financed by a payroll tax. Part B of Medicare (the Supplemental Medical Insurance program) provides coverage for physician-based services and is an optional program. About 25 percent of the program's costs are covered by premiums on enrollees, while the remainder of the program is financed through general revenues. When the Supplemental Medical Insurance program was first established, the implicit agreement was that the enrollees would pay 50 percent of the costs, the government the remaining 50 percent.

To support broader competitiveness efforts, the Council recognizes that changes to the Medicare program must be designed to control the actual growth in program costs rather than shift the burden onto the private sector. Simply implementing additional cost controls, such as those put in place by the Prospective Payments System, may shift rapid cost increases from the government to the private sector. Policymakers need to explore ways to rationalize costs throughout the health care sector — both public and private. Such changes might include:

— Increase and relate to the beneficiary's income the co-payments and premiums for both Part A and Part B of the Medicare program. The recently passed catastrophic health care legislation incorporated two concepts that the Council believes should be considered in reducing costs of other Medicare programs. The new benefits established by the legislation are to be financed by premiums and additional income taxes to be paid by the beneficiaries and the amount of the premium; in addition, the deductible is determined by the individual's income level.

Policymakers should consider measures to extend these financing principles to other Medicare programs. For example, requiring beneficiaries of both Medicare Part A and Part B to pay higher co-payments and premiums could contribute to deficit reduction. The existing premium for Part B, as mentioned, is well below the level intended when the program was introduced. In addition, relating increases to income levels would ensure that those with higher incomes pay a higher premium or co-payment, while those with lower incomes would have smaller or no increases. There are differing views on the effectiveness of higher co-payments and premiums on more effective use of physician and hospital services as well as on the critical objective of the overall slowing of health-care cost increases. Nevertheless, this option, along with proposals to slow health-care cost inflation, should be considered by policymakers.

— Develop mechanisms to better control the costs of both Part A and Part B of the Medicare programs. In addition, measures should be considered to reduce the cost of hospital services and out-patient physician services. Policymakers should take a close look at the inordinately high rates of growth in hospital-based physician services under Medicare Part A and physician-based services under Medicare Part B. Recent evidence shows little correlation between the cost of services and the rapid price increases. The Council urges exploration of ways to rationalize costs through the medical care system — public and private — and bring these costs closer in line with the Medicare Economic Index.

Means-tested programs

Recognizing that deficit reduction should not come at the expense of income-support programs for the most disadvantaged, the Council does not support reductions in means-tested programs. The means-tested (income-related) portion of the entitlement budget includes funding for programs designed to support low-income individuals. These include Medicaid; food stamps and other nutrition assistance for low- and middle-income families and individuals; Supplemental Security Income, which is cash payments to needy aged, blind or handicapped individuals; Aid to Families with Dependent Children; and veterans' pensions.

Over the past decade, the number of persons in poverty has increased. Between 1979 and 1986, there was a 24.2-percent increase in the number of individuals who fell below the poverty line. If food, housing subsidies and medical benefits are included as income, the number of individuals falling below the poverty line decreases (from 6.3 million to 5.6 million), but it results in a faster increase in the poverty rate — 36.1 percent between 1979 and 1986. Unfortunately, the fastest-growing segment of the poor has been children.

Benefits provided by means-tested programs are directed toward the truly needy. Additional cuts cannot be made in good conscience when savings can be achieved through entitlement-payment reductions that have a far less deleterious effect on an individual's means of support.

Retirement and disability programs

Option: Reduce the cost of federal and military retirement programs. Beneficiaries of programs in the retirement and disability accounts include civil service retirees, military retirees and retired railroad workers and coal miners. Nearly all of the federal government's civilian employees are covered either by the Civil Service Retirement System or the Federal Employees Retirement System. Under existing law, approximately 2.1 million retirees and survivors will receive payments totalling $29.3 billion in FY 1989. Approximately 1.6 million military retirees and survivors will receive an estimated $20.3 billion in payments in FY 1989. Retirement and disability payments for railroad workers and coal miners are expected to be about $5 billion in FY 1989.

There are a variety of means to reduce the costs of these programs. One that merits special attention is limiting COLAs for non-disabled retirees under the age of 62. Currently, about 60 percent of military retirees and 10 percent of the civil service retirees are non-disabled retirees under age 62. Benefit payments in FY 1988 for this population were $15 billion.

COLAs for federal retirees who begin receiving benefits before age 62 are fully paid for by the government and are expensive compared to the scheduled adjustments of the largest and most generous private pension plans. The Council believes that limiting the COLAs could reduce the incentives for early retirement.

Other programs: Farm-price supports

Option: Change the farm-price support programs to restore greater reliance on market forces. This could be accomplished either by further reducing target prices or reducing the base upon which deficiency payments are calculated. In response to shrinking farm exports and a depressed farm economy, Congress adopted a new farm policy late in 1985. Although the new policy retains elements of the former one, it also charts a new direction. The basic premise underlying the 1985 Food Security Act is that to regain its economic health, American agriculture had to reestablish its competitive position in international markets. Due to a combination of factors, including the price-enhancing effects of past commodity programs, U.S. farm products had become overpriced in foreign markets.

To remedy this situation, the new policy provided for significant reductions in the level of price supports for basic field crops. At the same time, to protect farmers' incomes from the effect of lower market prices, the increased use of direct payments also was authorized.

The principal means of adjusting supply to demand under the new policy continues to be voluntary acreage reductions, with the share of base acreage to be idled each year determined by the Secretary of Agriculture. Compliance with the prescribed acreage reduction is required for a farmer to qualify for direct payments and price supports. In addition, a long-term conservation-reserve program was initiated. This program, which will enroll 40 million to 45 million acres by FY 1990, idles highly erodible land for a 10-year period.

It was recognized when it was being developed that the new policy would be expensive. In comparison with an average annual net outlay of $4 billion for the FY 1977 farm bill and $14 billion for the FY 1981 farm bill, annual outlays for this measure were $24 billion in FY 1986 and FY 1987. Fortunately, due to a combination of program adjustments and improving market conditions, program costs are expected to decline over the next two years. FY 1988 costs are estimated to be $17 billion, falling to $12 billion in FY 1989 — still well above the levels of the late 1970s. (These figures do not include the costs of the drought program enacted earlier this year.)

The Council believes that further budget savings could be achieved by reducing target prices by an additional 5 percent or reducing the base upon which deficiency payments are calculated. Budget savings by FY 1993 could be as much as $2 to $3 billion.

Non-defense discretionary programs

Proposed Spending Caps. $202 billion in FY 1990, $203 billion in FY 1991, $210 billion in FY 1992 and $214 billion in FY 1993.

Non-defense discretionary spending includes funding for all programs not previously mentioned that are subject to annual appropriations or to loan or obligation limits imposed in appropriations acts. A large portion of this category is composed of the salary and expense accounts used to finance the operations of the civilian government agencies. Also included are programs to support national infrastructure development, energy development, natural resource management, educational and housing assistance, international aid, and research and development activities.

Although the non-defense discretionary portion of the budget has decreased in real terms since FY 1981, the Council believes that additional budget savings are possible. In reducing this portion of the budget, the Council believes that two objectives should guide the effort. First, consideration should be given to reducing or eliminating subsidies to certain sectors that may no longer need these subsidies. Second, those individuals who use specialized government goods and services — and are capable of paying —should pay the true costs of such goods and services. Finally, while recognizing the need to maintain a strong federal work force, consideration should also be given to addressing efficiencies in employment levels of the federal government.

A number of examples may be useful in demonstrating the type of changes the Council recommends be considered. In the area of eliminating subsidies for certain sectors, the federal government could reduce the subsidies provided by the Rural Electrification Administration (REA) to rural electric and telephone cooperatives. Because the 5-percent interest rate on REA loans is substantially below prevailing market rates, Congress has been required to provide funding to the REA to cover interest-rate losses. Given that analysts believe that the REA has largely fulfilled its goal of making electric and telephone service available in rural communities, this may be an appropriate area for reducing federal subsidies.

In the area of increased fees for specialized government services, the Council suggests that policymakers consider increasing user fees for various federal safety programs. While more than 90 percent of safety spending for highway and pipeline users is paid through user fees and more than one-third of aviation safety is paid for by users, only about one-tenth of the program for boaters is paid from user fees. Increasing charges to cover the costs of federal safety services would eliminate a subsidy paid by the general taxpayer for those individuals who can afford private boats and planes.

Revenues

The Council recognizes that under the CBO's assumptions about economic growth, employment and interest rates, reducing the deficit on the spending side of the ledger alone would require draconian reductions in federal spending. In fact, federal spending would have to be cut in real terms by 1.5 to 2 percent across the board. This would clearly involve more than trimming the fat from federal programs. In certain instances, it could involve wrenching program changes that could affect national security as well as some of the nation's neediest citizens.

The Council does not believe that the deficit gap can be closed absent additional revenues without undermining American competitiveness, threatening national security or breaking the nation's longstanding commitment to equity. If a formula for deficit reduction without new revenues proves as elusive to the new Administration and Congress as it has to us, the Council urges policymakers to consider new revenues to close the $121-billion deficit gap projected by the CBO for FY 1993 (which still includes the Trust Fund surpluses). We urge that this be done cooperatively and with the highest priority. The Council recommends that the same three tests that guided reductions in federal spending also govern the review of potential revenue increases: the short-term sacrifice should be widely shared; the new revenues should be as progressive as possible; and the new revenues should seek to minimize any adverse effect on private saving, investment and economic efficiency.

Understanding the options

A major contributing factor to the emergence of structural budget deficits in the 1980s was a reduction in revenues — triggered by both changes in tax policy and the recession. At the same time that federal spending increased to approximately 23 to 24 percent of GNP in the 1980s, revenues as a percentage of GNP were only slightly higher than previous averages, resulting in a federal budget deficit well in excess of $200 billion in a number of years *(Table 6).*

The decline in revenues that characterized the early 1980s has been reversed somewhat as a result of three factors: tax reform efforts that have

Table 6

Federal Revenues as a Percentage of GNP

Average of the 1960s	18.2%
Average of the 1970s	18.3%
Average of the 1980s	19.0%
Projected Average FY 1990 to FY 1993	19.4%

Source: Derived from Congressional Budget Office data

increased taxes, particularly on business; stronger economic growth and higher corporate profitability; and higher receipts from social insurance taxes. The combined effect is that revenues are estimated to rise to approximately 19.4 percent of GNP by FY 1993. Nevertheless, the gap between revenues and spending remains significant.

As noted in *Chapter 1*, comparing current or projected levels of revenues with historical trends should not be used as the only benchmark for the level of spending or revenue the nation should pursue. *Chapter 1* further pointed out that the composition of spending and revenues provides a better guide to determining future requirements. In reviewing the changing composition, several trends stand out (see *Figure 4*).

First, income taxes, as a percentage of total revenues, have remained relatively constant over the past 30 years, and their share of total revenues is not projected to change substantially into the early 1990s. Changes in the tax code in the 1980s, however, have shifted the burden of income taxes among various income groups. For example, in the 1980s, marginal tax rates on upper-income individuals have fallen dramatically — from 70 percent to 28 percent. In addition, as a result of the 1986 Tax Reform Act, the lowest-income individuals no longer are required to pay taxes.

Second, corporate income taxes have fluctuated. While corporate receipts fell to a low of 7.8 percent of total revenues in FY 1982, by FY 1993 they are expected to represent approximately 11 percent of total revenues. Higher corporate taxes have resulted from two phenomena: the elimination of incentives such as the Investment Tax Credit; and improved corporate profitability. As a result, the taxes of the top 250 corporations — a group that accounts for one-third of total corporate profits — averaged 22 percent of total profits in 1987, up significantly from the average of 15 percent between 1981 and 1985. Corporate taxes as a percentage of total revenues are still below the levels of the 1960s and early 1970s. But this reflects a decline in corporate profitability as well as tax code changes that were intended to enable U.S. firms to compete in an increasingly competitive international market.

Third, excise taxes have continued to decrease as the government deliberately tried to increase the progressivity of the tax code. Excise taxes have fallen as a percentage of total revenues from 12 percent in FY 1962 to less than half that today.

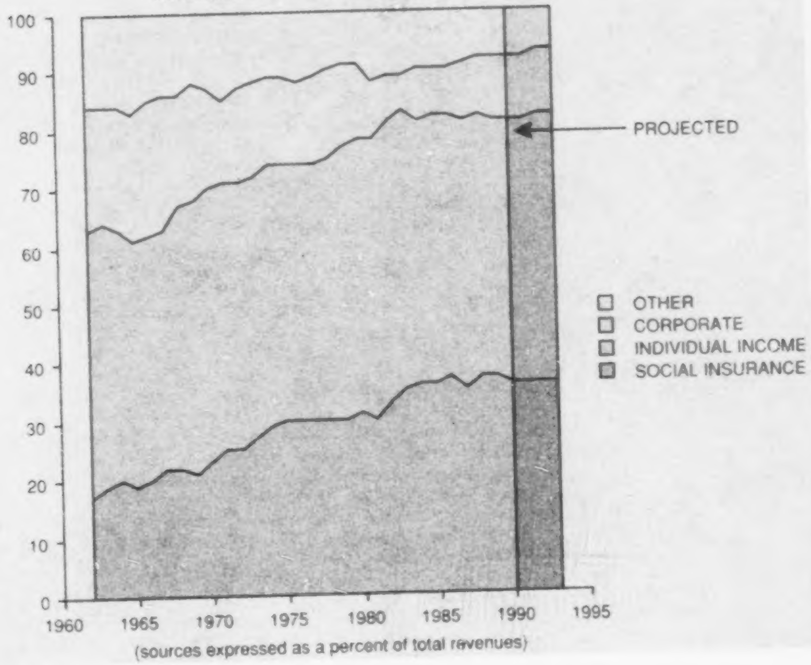
The final and most dramatic change in federal revenues has been the enormous increase in the levels of social insurance taxes. Social insurance taxes have almost doubled as a percentage of total revenues between FY 1962 and FY 1989 — from 17 percent of total revenues to 33 percent. By FY 1993, that percentage is expected to be 37 percent.

An even more telling breakdown in the composition of taxes is shown in *Figure 5*. In this figure, social insurance taxes are divided among those groups that pay them. Business pays approximately 37 percent of total FICA taxes; individuals, 50 percent; and the self-employed and governments, the remaining 13 percent. This breakdown of who pays for the cost of government programs shows that receipts from business (with the exception of a period in the early 1980s) have remained, and are expected to remain, constant at approximately 25 percent of total receipts. Individual income taxes have increased by about 10 percent. Clearly, the most dramatic decrease in revenues is from the "other" category, which is composed largely of excise taxes.

A review of revenue levels and their changing composition reveals a fundamental cause of the nation's deficit problem. If social insurance receipts are eliminated from total revenues, remaining revenues would total 12.2 percent of GNP in FY 1993. This level of revenues is less than levels of non-social insurance revenues of the 1960s and 1970s. It is woefully inadequate to finance the level of non-Social Security spending predicted for FY 1993, which in itself has been on a downward trend as a percentage of GNP since the mid-1980s.

FIGURE 4

REVENUES BY CATEGORY: 1962-1993



Source: Council on Competitiveness based on Congressional Budget Office data

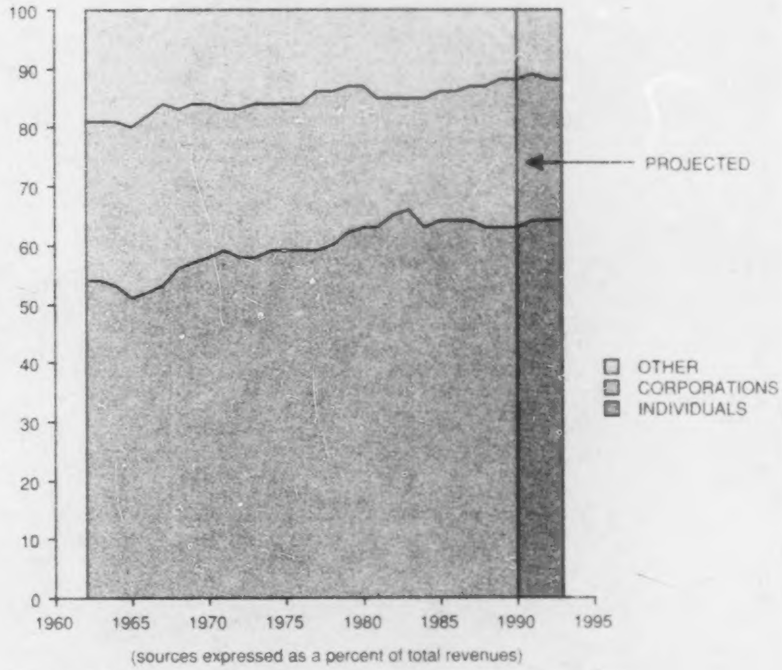
While the tax burden on individuals has increased and the burden on corporations remained steady, more and more of these revenues are designed to pay for Social Security, not to support general federal spending.

Possible revenue-raising options

The Council has developed a number of revenue options that illustrate the types of revenues that could meet the short-term goal of deficit reduction while maintaining progressivity and minimizing adverse effects on private saving and investment. The options listed below could raise as much as $70 billion in FY 1993. Not all of these options would need to be implemented to meet the short-term goal of reducing the budget deficit by $120 billion by FY 1993. Given the Council's $48 billion in proposed spending reductions and related interest saving associated with deficit reduction, approximately $48 billion in revenues would be needed in FY 1993. Increased spending for competitiveness-related programs, discussed in detail in *Chapter 3*, should be netted out against the overall budget

FIGURE 5

REVENUES BY SOURCE: 1962-1993



Source: Council on Competitiveness based on Congressional Budget Office data

deficit — either through additional spending cuts or revenue increases.

Option: Restore real levels of excise taxes. Effective excise-tax rates have declined significantly over the past three decades. The excise tax on cigarettes is now less than 15 percent of the current average market price (including tax per pack), significantly less than the 42 percent of the price it represented in 1951.

The tax on distilled spirits has similarly declined and the real value of the tax is much lower than it was in 1951.

The per-unit taxes on beer and wine also have not changed since 1951. Moreover, beer and wine are taxed much less heavily than distilled spirits. Increasing the taxes on beer and wine to a level equivalent to the current tax on distilled spirits would ensure that tax policy treats all alcoholic beverages similarly.

Even partially restoring excise taxes would raise large amounts of revenue. Doubling the tax on cigarettes to 32 cents per pack, increasing the tax on distilled spirits by $2.50 per gallon and raising the taxes on wine and beer to an alcohol-equivalent level would raise approximately $8 billion in FY 1993.

Excise taxes are regressive; because lower-income individuals spend a greater proportion of their income on these products, they would bear a disproportionate burden of such tax increases. Nevertheless, these taxes are on discretionary purchases, not necessities. In addition, because these taxes are on consumption, they meet the test of minimizing any adverse effect on saving and investment.

Option: Raise motor-fuels taxes. Federal motor-fuels taxes are currently 9.1 cents per gallon on gasoline and 15.1 cents per gallon on diesel fuel. The revenue from these taxes is earmarked for the Highway Trust Fund — which pays for the construction and improvement of interstate highways, bridges and mass-transit facilities — and for the Leaking Underground Storage Tank Trust Fund. State governments can impose gasoline taxes ranging from 7 cents to 20 cents per gallon. Compared with other countries, many of which levy taxes of well over $1 per gallon, the United States' taxes on motor fuels are among the lowest in the world. Because the average national price of gasoline has dropped from a peak of about $1.39 per gallon in March 1981 to slightly above $1 today, an additional tax of up to 20 cents should not raise the total cost of gasoline above what consumers have already experienced.

Economists estimate that for every 1-cent increase in the federal motor-fuels tax, revenues are increased by approximately $1 billion. Consequently, a 20-cent-per-gallon increase could raise significant amounts of new revenue. Because low-income families spend a greater percentage of income on gasoline, these taxes are regressive. The Council believes that any effort to increase the motor-fuels tax must be complemented by provisions to address regressivity. The Council also believes that consideration should be given to designating some portion of any new revenues to the Highway Trust Fund for infrastructure development and repair.

In terms of U.S. manufacturing competitiveness, motor-fuel taxes would not increase manufacturing costs directly. However, a motor-fuels tax increase would affect U.S. industry, as about 30 percent of U.S. motor fuel is used directly by business. Increased motor fuels taxes could also reduce personal disposable income and could have a marginal negative effect on private saving. However, this could be expected to be offset by the increased levels of national saving associated with deficit reduction.

Two additional benefits associated with higher federal motor-fuels taxes could be improved conservation and a possible reduction in oil imports.

Option: Broaden the tax base for individuals and corporations. The 1986 Tax Reform Act moved in the direction of removing consumption biases in the tax code by terminating the deduction for consumer-interest costs. However, a major exception has been the continuation of the deduction on loans secured by a taxpayer's residence regardless of how the loan is used. This deduction has continued a subsidy for consumption and has been used by taxpayers to fund everything from art objects to fur coats.

To ensure that the spirit of the 1986 Tax Reform Act's effort to reduce subsidies for consumption is not undermined, the Council recommends that policymakers consider restricting the deduction to loans that are used only to improve a home or to finance an investment such as post-secondary education.

In addition, although deductibility for consumer-interest loans will be phased out by FY 1990 under the 1986 Tax Act, full deductibility of mortgages on second homes used for vacation purposes has been retained. This provision, which could be viewed as a subsidy for those able to afford a second home, functions as a major incentive to invest in real estate.

Limiting the home-equity interest deduction to home improvements and college education, as well as phasing out the deduction for second homes, could yield increased receipts of $9 billion over a four-year period and $3 billion in FY 1993. Limiting the use of the deduction for home-equity loans would be progressive in that it would eliminate an incentive to consume only for those who have equity in their homes. Phasing out the second-home deduction would be progressive as these deductions are used by upper-income individuals for vacation homes. These options would eliminate incentives for consumption, steer investment into assets other than real estate and possibly increase personal saving.

Any additional revenues from business should be derived from broadening the corporate tax base. The 1986 Tax Reform Act significantly increased corporate taxes. Reductions in corporate tax rates were more than offset by repeal of the investment tax credit, changes in numerous other tax deductions and toughening the alternative minimum tax. However, the Council recognizes that there are tax-code provisions that permit specific business taxpayers to reduce or avoid tax payments. The Council encourages the new Administration and Congress to eliminate those provisions, except for those that have a positive impact on productivity, exports or efforts to commercialize technology. These changes should be designed to generate new revenues of approximately $5 billion in FY 1993.

Option: Improve tax compliance. IRS audits indicate that about $110 billion in potential tax revenues are lost each year because income is not reported. While only 6 percent of wage and salary income goes unreported, almost one-sixth of dividend and interest income and one-half of capital-gains income is not reported to the tax authorities. Tax cheating undermines the fairness of the tax system and redistributes income from honest to dishonest taxpayers. Curtailing cheating would be desirable even if there were no budget-deficit problem.

The extent to which tax revenues can be increased through improved enforcement efforts is a subject of intense debate. Three facts are not in dispute, however. First, the percentage of returns subject to audit has declined from 5 percent in the mid-1960s to 2.5 percent in the mid-1970s to approximately 1.1 percent today. Second, where taxes are withheld or information reporting is required, compliance is much better than in situations where the IRS relies only on voluntary reporting. Third, newly hired auditors generate increased revenue collections that cover their salaries many times over, even without allowing for the generalized deterrent effect of an expanded IRS presence.

A program to improve compliance through a combination of measures — restoration of the audit rate to its 1970s' level, increased publicity regarding IRS enforcement efforts, withholding requirements on dividend and interest income, and information reporting on capital gains — could increase tax collections by as much as $5 billion a year after several years, according to a 1988 report by the General Accounting Office on recent experience in tax compliance.

Option: Institute a formal 33-percent income-tax rate and expand its application to upper-income individuals. The current 33-percent rate — applicable to those families of four with incomes between $79,500 and $200,350 — results from a surcharge on the 28-percent rate designed to recapture the benefits of the 15-percent bracket and the personal exemption for higher-income taxpayers. Taxpayers with incomes above this face a 28-percent marginal rate. Making the 33-percent rate explicit and extending the rate to *all income* above the level where the implicit 33-percent rate currently begins ($79,500 for a family of four) would affect only about 600,000 taxpayers.

Increased receipts from this proposal would be $22 billion over a four-year period and $7 billion in FY 1993. Increasing taxes on the highest-income individuals is progressive, particularly given that marginal tax rates for this group have declined significantly in the 1980s. Increasing taxes on those individuals with the highest propensity to save may have a marginally negative effect on personal saving. However, the marginal tax rate would remain less than half the 1980 rate, and the substantial decrease in rates since then has not resulted in high levels of private saving.

Option: Impose a temporary surtax on individual income. Under this surtax proposal, taxpayers would compute their normal tax liability, then add 5 percent. The surtax would be sunsetted after four years. For individuals, long-term capital-gains activities that generated saving and investment would be exempted from the surtax, thus temporarily restoring the differential between capital-gains income and ordinary income. The 5-percent surtax would be roughly equivalent to raising the FY 1988 individual tax rates temporarily from 15 percent, 28 percent and 33 percent to 15.75 percent, 29.5 percent and 34.6 percent, respectively.

Four-year receipts from the individual-income surtax would be approximately $83 billion and $25 billion in FY 1993. Because the surtax is computed as a percentage of taxes, it is generally viewed as being progressive. The break-out for income generated through certain capital-gains activities could minimize any adverse effect on levels of private saving.

Conclusion

The options advanced by the Council provide one means by which the budget deficit can be reduced in the short term. There are clearly many other deficit-reduction options — on both the spending and revenue sides of the ledger. In developing its options, the Council has been guided by a desire to maintain progressivity, ensure that all sectors contribute to deficit reduction and minimize any adverse effect on private saving and investment.

Even this package, however, is not sufficient to ensure that U.S. fiscal policy promotes U.S. competitiveness. It is merely the first step. A longer-term effort to move the nation away from consumption and toward saving and investment is required if the United States is to safeguard future living standards. The following chapter discusses how this could be achieved.

CHAPTER 3

A LONGER-TERM FISCAL-POLICY AGENDA

Chapter 2 illustrated a deficit-reduction program that would address the short-term problem of a low national saving rate. Restoring saving rates is necessary to ensure an adequate level of resources needed to finance investments that will promote increased productivity, economic growth and improved living standards for the United States.

Deficit reduction is the crucial first stage of developing a fiscal policy that promotes American economic competitiveness. But it is not the only step. Over the longer term, additional policy changes are required to move the nation away from consumption and toward saving and investment.

Three issues require the attention of the new Administration and Congress. First, a higher priority should be given in the federal budget to public programs that support productivity growth and technological advances. The *1988 Economic Report of the President* highlights three factors that underlie increased living standards over the longer term. According to that report, "...the output available for current consumption, or for investment to augment future consumption, is determined by: (1) the quantity and quality of labor, capital and natural resources; (2) the technology used in production processes; and (3) the mechanisms that allocate inputs in production processes and distribute goods and services to final users." The federal government supports a number of programs that are essential to these three factors. That role should be strengthened during the 1990s.

Second, the nation should place the Social Security Trust Fund on a sound footing. Currently the Trust Fund surpluses, designed to pay for the baby boomers' retirement, are being used to mask the true size of the deficit. Continuing this practice would seriously compromise efforts to increase levels of national saving.

Finally, consideration should be given to restructuring federal tax policy to encourage increased levels of private saving and investment.

Pursuing action on this longer-term agenda will build on the accomplishments of short-term deficit reduction and lay the foundation for long-term economic competitiveness. This chapter examines these three fiscal-policy goals.

Pro-Competitive Spending Priorities

RECOMMENDATION: Shift federal spending priorities to emphasize programs that improve productivity. Increased investment is required to develop and expand the scientific and technological base, develop human resources and rebuild the nation's infrastructure. Given the short-term goal of deficit reduction and the need to develop effective delivery systems before additional funds are appropriated, increases in funding should be phased in over a multi-year period.

Reducing the federal budget deficit — and raising levels of national saving — is the primary tool available to federal policymakers for encouraging the nation's long-term competitiveness. The nature, scope and priorities of future federal spending, however, will affect significantly the much-needed investments in programs that underpin long-term competitiveness.

The Council believes that over the long run, the nation will not be able to maintain or raise its standard of living without attending to problems such as its troubled education system, deteriorating physical infrastructure and declining technological leadership. In most instances, addressing these problems requires increases in federal funding. The Council suggests that small increases in spending for programs related to technology, education and infrastructure begin in FY 1990, with additional increases occurring after credible deficit reduction is well underway.

Science and technology

RECOMMENDATION: To strengthen the development and commercialization of technology, increase federal funding by approximately $1 billion a year, beginning in FY 1990.

Technology has made a vital contribution to America's economic growth and high standard of living. It has improved manufacturing efficiency, created entire industries and served as an important source of U.S. export strength. Leading economists argue that technology is directly or indirectly responsible for two-thirds and perhaps as much as 80 percent of the productivity growth since the Depression. Clearly, America must effectively develop and deploy technology to compete in world markets. (For a full discussion of the relationship between technological development and economic competitiveness, see *Picking Up the Pace: The Commercial Challenge to American Innovation*, Council on Competitiveness, September 1988.)

Today, the U.S. economy is being pushed toward greater reliance on technology. Structural changes in the economy make the nation more reliant on technology-based sectors and on technology-based improvements of traditional industries as the foundation for national competitiveness. Vigorous competition from low-wage countries in traditional industries and other industrial countries in technology-based industries require the United States to build and sustain a competitive edge based on technology. As the race to develop and commercialize new technologies intensifies, the United States must pay even greater attention than it has in the past to scientific and technological advancement.

Over the years, the federal government has contributed significantly to America's scientific and technological development. In addition to providing support for science and math education from the high school to post-graduate levels, the federal government helps finance university research facilities, underwrites research and development projects in the nation's universities and is now beginning to back cooperative R&D programs in the private sector. To strengthen the U.S. position in research and development and address some emerging scientific and technological problems, the Council recommends additional federal spending for the National Science Foundation and university research facilities.

National Science Foundation (NSF). The Council recommends doubling the NSF budget from its FY 1988 funding level of $1.6 billion to $3.2 billion by FY 1993.

In his FY 1988 budget, President Reagan recommended doubling the NSF budget over five years from $1.6 billion to $3.2 billion. In the final budget negotiations for FY 1988, total NSF funding was increased to $1.7 billion — 5.8 percent above the FY 1987 level, but $176 million less than the 17-percent increase necessary to meet the President's proposal. Although total federal R&D support has increased by almost 100 percent over the past seven years, 90 percent of this increase has been for defense-related R&D. As a result, real federal support for civilian R&D in FY 1988 is 14 percent below its FY 1980 level. In real terms, NSF research funding has remained essentially level over the past 20 years. Because federal R&D represents a critical investment in U.S. competitiveness, the proposed doubling of the NSF budget over five years should be accomplished.

Within an expanded NSF budget, two programs deserve special attention. First, federal funding for cooperative R&D projects should be increased. This is a relatively new venture for the federal government and may bring beneficial and cost-effective results. Programs in this category that should be supported on a pilot basis include those such as the NSF Engineering Research Centers. Projects like these should be closely monitored to assess their effectiveness.

Second, to encourage Americans to pursue technical studies, federal funding for science and engineering education should be increased over a period of several years. Because America's ability to commercialize technology is linked closely to its supply of skilled technical workers, the nation must ensure that it has an adequate supply of individuals trained in technical disciplines. Presently, the education system is failing to produce the American scientists and engineers needed to meet future demand. With a decreasing number of 18-year-olds in the U.S. population and a declining percentage of high school graduates choosing science and engineering, a shortfall of more than 500,000 scientists and engineers is projected by the year 2010. Substantial additional funds for science and engineering education are required to help prevent the emergence of such a shortage. To address this problem, the Council also recommends that the Department of Defense increase the funding in its basic research budget for science and engineering fellowships and graduate research.

University research facilities. The Council endorses providing $5 billion in increased funding over the next 10 years for modernizing university research facilities. This would require an annual increase of approximately $500 million. Over the past 20 years, federal funding for university research plant and facilities has declined 95 percent in real terms. Legislation has been introduced to provide $5 billion in funding for upgrading the university infrastructure over the next 10 years. The Council supports passage of this legislation and appropriation of funds.

Human resources

RECOMMENDATION: Provide increased funding for human resource development with some increases beginning in FY 1990 and increasing throughout the next decade. Where additional training and educational facilities are required, funding should rise slowly to allow efficient delivery systems to be put in place.

Development of America's human resources is essential to increased competitiveness. In a global economy, America cannot hope to compete against low-wage countries solely on the basis of absolute labor costs; instead it must ensure that productivity growth is vigorous. Since other high-wage industrial countries are approaching America's performance in worker productivity and surpassing it in some industries, the United States must also develop advantages in areas such as technological innovation and commercialization. To achieve both objectives, the United States must cultivate a superior labor force.

Historically, state and local governments have provided the lion's share of human resource investments. Yet, the federal government has played, and continues to play, an important role in human resource development through programs designed for special populations such as the economically and educationally disadvantaged.

The Council believes that the human resource commitments the federal government should expand fall into four broad categories. First, more funding is needed to help bring disadvantaged youth into the mainstream of society. Second, additional funds are needed for special programs in math and science to produce individuals qualified to operate in an increasingly complex technological society. Third, programs must be expanded to broaden access to post-secondary educational institutions. Fourth, funding is needed to retrain dislocated workers so that they can again become productive members of the work force.

Disadvantaged youth. The Council recommends increased funding for programs for disadvantaged youth, including the Women, Infants and Children (WIC) program, Head Start and Chapter I.

Public investments in the nation's disadvantaged youth are crucial, especially at the present time. In considering the worthiness of such expenditures in a climate of deficit-imposed restraint, it is important to remember that disadvantaged youth will comprise a significant portion of the future labor force. It is equally important to recognize that hungry or sick children cannot learn. Children born with otherwise preventable birth defects enter school with a tragic disadvantage. Children from broken homes and children of poverty begin school with heavy burdens that most schools are ill-equipped to deal with. Moreover, the early years of a child's development are a critical determinant of whether a student will eventually drop out of school. Effective early intervention can improve the quality of child development and education, and reduce later dropout rates.

Children who do poorly in school, in turn, are almost certain to become a burden on society. The social costs, while difficult to accurately quantify, are high, surely in the billions every year. Crime, delinquency, welfare and health costs are higher among the less well-educated than the educated. Of course, the converse is true as well — educated people contribute significantly to productivity improvements and the nation's standard of living. Increases in the following three programs should help lay solid health and educational foundations amongst disadvantaged children and draw them into the economic mainstream.

— The WIC program. The early years of a child's life play a large role in determining subsequent educational achievement. Children who lack proper nutrition, health care and parental involvement generally perform more poorly than other children in elementary and secondary school. Studies have shown that when low income is compounded by cultural or community circumstances that inhibit early childhood development, the likelihood of future student success is diminished.

Early childhood intervention is essential to help promote child development. One effective federal intervention is the Women, Infants, and Children program. Evaluation of the WIC program reveals that it reduces fetal deaths by one-third; reduces premature births among high-risk mothers by 15 to 25 percent; and shows increased brain growth and evidence of cognitive development among preschoolers who are WIC participants. WIC currently serves 3.3 million low-income families, less than half the eligible population, at a cost of $1.7 billion. The program should be expanded to serve more eligible children.

— Head Start. Quality development support must be followed up with effective pre-school programs. The federal government is involved in pre-school programs for the disadvantaged through Head Start. This program is universally well regarded as providing effective pre-school education. A review of Head Start evaluation studies reveals that the program improves children's performance on school achievement tests, helps children learn socialization skills, reduces school absenteeism and health problems, and improves parents' attitudes toward their children. Quality pre-school also lowers the likelihood that a student will drop out of the education system. Head Start's current budget of $1.13 billion serves 450,000 children, less than 19 percent of the 2.4 million eligible. Additional funding is needed.

— Chapter I. The federal commitment to education of the disadvantaged must be sustained through elementary and secondary school. Chapter I of the Education Consolidation and Improvement Act is the principal federal program for upgrading the educational environment for disadvantaged elementary and secondary students. Currently, the federal government spends approximately $3.8 billion a year on this program, yet only half of the eligible students are being served. Here, too, additional funds are required.

Math and science programs. The Council recommends increased funding to strengthen programs to train math and science teachers.

According to the NSF, some 60,000 math and science teachers in America's secondary schools are not fully qualified. By 1995, the United States will need an estimated 300,000 additional qualified secondary-school math and science teachers.

The federal government presently administers a program to help recruit, retain and retrain math and science teachers in elementary and secondary schools. For FY 1989 the President proposed $119 million for this program, a decline in real terms from FY 1988 levels, and well below the authorized funding level of $350 million. Funding for this program should be increased to help increase the competency of existing teachers and attract potential science and math teachers to the profession. Poor teachers contribute to negative student attitudes about science and math.

Post-secondary education. The Council recommends higher levels of funding for programs to ensure post-secondary access for low-income students. Historically, the federal government has played an important role in post-secondary financial support for disadvantaged youth. With the escalating costs of higher education, these federal programs have become increasingly vital. One of the top priorities in financing college and university education is to ensure adequate support for economically disadvantaged students qualified for post-secondary education but unable to afford it. Current federal programs do not provide the resources needed and should be expanded.

Dislocated workers. The Council recommends funding for the new program to assist dislocated workers.

Following its year-long review of federal programs to aid displaced workers, the Secretary of Labor's Task Force on Economic Adjustment and Worker Dislocation recommended extensive changes to existing federal unemployment-assistance programs. The program was recently authorized in the Omnibus Trade Bill. The changes are designed to promote the re-employment of workers who lost their jobs as a result of permanent layoffs or business failures. The program will provide a variety of services to dislocated workers, including counseling, job-search assistance and employment retraining. The Council supports full funding for this program.

Infrastructure

RECOMMENDATION: The nation's deteriorating physical infrastructure must be repaired and improved. To achieve this, a portion of additional revenues from a federal motor-fuels tax should be designated for highway development and repair. Funding levels for infrastructure should be maintained at real growth rates. Resources in infrastructure trust funds should be earmarked for infrastructure improvements and not be used for reducing the deficit.

America's infrastructure — which includes its bridges, roads, dams, airports and waterways — is an important underpinning of the economy and a key element in the nation's economic development. Unfortunately, America's infrastructure is deteriorating more rapidly than it is being repaired and replaced.

The nation is presently not making sufficient infrastructure investments. The Department of Transportation reports that if the nation's roads continue their present pace of decline, by 1995 deteriorated roads will cause an absolute reduction in the annual outputs of many industries, leading to slower GNP growth, higher inflation, lower productivity and a decline in real disposable income.

The federal government has played an important, but not exclusive, role in funding America's infrastructure. Historically, the federal government has provided as much as one-third of the total funding, although the percentage has fallen to as low as 27 percent. Federal support has been concentrated in three key areas: the national transportation network, including the nation's airport and air traffic control system; public transit repair and modernization and the Federal Highway Administration; water-resource management; and hazardous waste disposal and sewage treatment.

The Council recommends that, at a minimum, funding for infrastructure should remain constant in real terms, and that if a federal motor-fuels tax increase is adopted, a portion of the revenues should be used for infrastructure development. Furthermore, resources currently in the Highway Trust Fund should be used for infrastructure development rather than for deficit reduction.

The Council also believes that infrastructure development undertaken by state and local governments and by private groups, which is sensitive to interest rates, will be positively affected by lower rates of interest associated with deficit reduction.

Ensure the Soundness of the Social Security Trust Fund

RECOMMENDATION: Guarantee the integrity of the Social Security Trust Fund. Specifically, fund surpluses should not be used to mask the true size of the budget deficit. Rather, they should be used for their intended purpose: to pay for the retirement benefits of the baby-boom generation.

In 1983, as an outgrowth of recommendations of the Greenspan Commission on Social Security, Congress and the Administration took major and controversial steps to put Social Security on a sound long-term financial footing. The most significant departure proposed by the Commission was to increase payroll taxes on current workers to a level that would allow the Social Security Trust Fund to run a surplus, effectively requiring the current generation of workers to finance a large share of their own Social Security benefits. This stands in sharp contrast with the traditional practice of paying Social Security benefits of retirees out of current work force payroll taxes. In other words, for the baby-boom generation, the Social Security system is being transformed from a "pay-as-you-go" plan to a pre-paid plan.

Demographic realities necessitated either this change or a major payroll tax increase when the baby boomers retire. In 1952 there were 17 workers to support a single retiree; by the turn of the century, there will be only 1.5 workers for each retiree. Payroll taxes on future workers might have had to increase to as much as 40 percent to generate sufficient revenues to pay for the baby boomers' retirement benefits. The accumulated surplus is intended to resolve this problem by pre-funding benefits. The Trust Fund is already beginning to amass large annual surpluses — as much as an estimated $99 billion in FY 1993.

These surpluses are being used to cover deficits in other federal programs. As noted earlier, the CBO projects that in FY 1989 the deficit, including the Social Security surplus, will be $148 billion — *falling* to $121 billion by FY 1993. If the surpluses are excluded, however, the deficit actually *rises* from $199 billion in FY 1989 to $220 billion in FY 1993.

The Council's deficit target proposed in *Chapter 2* would close the gap between revenues and expenditures by $120 billion by FY 1993. That leaves an additional deficit, which under current projections is the size of the annual Social Security Trust Fund surplus, to be reduced. The Council did not support additional reductions out of a belief that approximately $30 billion in annual deficit cuts is the maximum feasible in the near term. Otherwise, the nation might be thrown into a recession, competitiveness might be undermined or national security might be endangered.

Over a long period, however, the surpluses should be allowed to accumulate as a reserve to fund future retirement benefits and the other portions of the budget should be brought into balance. Moreover, to ensure that the growing surpluses are also *not* used to support other federal programs or do *not* lead to lower payroll taxes or expanded Social Security benefits, the Council supports enactment of provisions to circumscribe their use. The surpluses should be dedicated to the retirement benefits of the baby-boom generation. This is the reason current workers pay such high payroll taxes, and the integrity of the agreement that raised payroll taxes to current levels should be maintained.

Achieving a balanced budget and running a surplus in the Social Security Trust Fund would have a very positive impact on private investment activity. The Trust Fund surplus may be used for only one purpose: the purchase of federal debt. As the Social Security Trust Fund buys up more and more federal debt, a much greater amount of investment funds will be freed for financing private sector activities. The availability of investment capital should increase significantly. Moreover, once the overall government budget is in surplus, the nation can adopt a looser monetary policy to offset the fiscal drag of a surplus. Such a policy would lower interest rates, encouraging private sector investment.

Some options to address the problem

Even if all of the Council's suggested spending cuts and revenue options are adopted, once the Trust Fund surplus is removed from deficit calculations, a deficit of approximately $110 billion will remain in FY 1994 — approximately 1.5 percent of GNP.

If revenues are required to close this gap in the non-Social Security portion of the budget, the nation should seek to adopt a mechanism that raises the necessary amounts of revenue with the least amount of distortion to the economy. In addition, any new tax should be designed to support the overriding competitiveness objective of minimizing adverse effects on saving and investment. There are three basic, alternative revenue choices to raise the requisite funds: an income surtax could be imposed; income-tax rates could be increased; or some type of broad-based consumption tax could be introduced.

There are strong arguments to support or oppose each of these revenue-raisers. Each deserves full consideration by the next Administration and Congress, as do other possible packages of budget changes to close the spending-revenue gap.

A combination of spending cuts or an adjustment of income-tax rates would basically represent a continuation of the existing tax and spending structure. The most dramatic change in taxes would be to adopt a consumption tax. A consumption tax is attractive because it could close the budget gap quickly, because each percentage-point increase in a broad-based consumption tax could generate approximately $20 billion in revenues. Even with exemptions for basic commodities or with subtractions to redress regressivity, the tax could generate $15 billion for each percentage-point increase.

There are, however, major unanswered questions about a consumption tax. For example, what would be the optimal consumption tax — a national sales tax, value-added tax or business transfer tax? Or, since the tax burden relative to income would fall most heavily on lower-income people who spend a greater portion of their income, how would the regressivity of such a tax be redressed? Would a consumption tax replace the existing tax system or supplement it? How would a national consumption tax mesh with state taxes? What kind of administrative mechanisms would be needed?

If the Administration and Congress address the long-term fiscal problems resulting from use of the Trust Fund to mask the deficit, a consumption tax might be an attractive alternative. Yet, the questions raised above must be addressed, particularly the regressivity issue. Because it represents a new direction for current federal tax policy, the discussion on the merits and drawbacks of a consumption tax, along with income-tax changes, should begin now within the context of ensuring the soundness of the Social Security Trust Fund.

A Tax Policy for Saving and Investment

RECOMMENDATION: Long-term restructuring of the tax code should support the objective of increased private saving. The tax code should also be made more consistent to improve the climate for long-term investment in productive assets.

Because federal dissaving is a major drain on the nation's pool of saving, reducing dissaving by lowering the budget deficit is the most powerful and certain means of increasing national saving in the short term. The deficit-reduction package outlined by the Council in *Chapter 2* illustrates how the first step to boost national saving could be taken.

Saving incentives: The role of tax policy

The federal government does not bear sole responsibility for the low rates of national saving. Saving rates of individuals and corporations, which were already low throughout the 1960s and 1970s compared to the saving rates of other industrial countries, have fallen to even lower levels in the 1980s. Net saving by individuals and corporations dropped to about 5 percent of GNP in 1987. This contrasts with a rate in the 1970s of about 8.5 percent of GNP. Moreover, the decline has occurred despite a long economic recovery.

The causes of the traditionally low saving rates of Americans, and the more recent decline in saving, are not adequately understood. One of the primary reasons for low saving rates may be a federal tax code that treats saving unfavorably. The existing code is a mix of levies against income and consumption, including the payments corporations and individuals make on gross earnings, and taxes on various products, such as gasoline, tobacco and alcohol.

Despite the elimination of many deductions for personal purchases by the 1986 Tax Reform Act, the tax code retains a series of deductions that amount to subsidies for certain types of investments or purchases. For example, home-equity loan interest remains deductible. Because home-equity interest deductions are not restricted to loans for specific purposes, debt could finance consumer purchases and still qualify for a deduction. Thus, this deduction provides a tax incentive to consume and implicitly acts as a disincentive to save. The Council believes that a reexamination of the tax code to identify policies such as this that discourage saving would represent a modest step in the right direction toward providing more explicit policy support for additional private saving.

A more ambitious and worthwhile objective would be to develop a tax code that specifically encourages higher levels of private saving. In the past, the federal government has experimented with tax incentives to increase personal saving. In 1981, the federal government expanded eligibility for Individual Retirement Accounts (IRAs), a saving-incentive program that allowed individuals to deduct from taxable income contributions to such accounts up to a threshold level. IRAs, in many respects, transformed the income tax to a consumption tax, since income was not taxed so long as it was saved — the major exception being that the program allowed the deduction only of a limited portion of income. The trial period for IRAs was brief. The 1986 Tax Reform Act severely restricted eligibility for IRAs.

The IRA program did demonstrate that the outcome of discrete tax incentives on saving rates cannot be predicted with certainty, because private saving actually decreased during the period when the eligibility for IRAs was at its peak. Still, increases in private saving are desirable and would certainly complement reductions in federal dissaving. The Council believes that a long-term restructuring of the tax code to provide greater saving incentives and fewer consumption incentives should be pursued. Because the relationship between saving and taxation remains poorly understood, the first step is to strengthen our understanding of how existing tax policies diminish private saving, and how alternative tax structures would encourage private saving.

Investment

In the past, the federal government also has instituted various policies to stimulate investment, such as the Investment Tax Credit. The 1986 Tax Reform Act eliminated many subsidies for investment. Although investment is required to expand productivity, the Council has three reasons for believing that encouraging investment is more effectively pursued by policies that expand saving, rather than by trying to create programs that subsidize investments.

First, with a limited pool of investment funds available, whenever specific investments are encouraged, other investments necessarily are discouraged.

Second, in the absence of changes in demand for the products resulting from investments in physical capital, there may be little desire among firms to expand investments simply because incentives are offered. Firms make decisions to invest based on the after-tax returns they project investments will yield. Orders for products and profits will determine the profitability of an investment to a much greater extent than a specific government-supplied credit.

Third, because of revenue losses associated with creating incentives, any salutary effects of credits or other incentives could be offset by increased federal borrowing and higher capital costs for the private sector, thus reducing other investments that would otherwise have occurred.

Instead of trying to micro-manage private investment decisions, the Council believes policymakers could help merely by improving the consistency of tax policy. Constant changes in federal policies create enormous uncertainty for the private sector. Indeed, if federal tax programs related to investment have one mark of consistency, it is their erratic definition and application. Year-to-year changes in programs hamper the efforts of planners and investors attempting to make long-term decisions. On-again, off-again policies have added volatility to the already-risky investment process. Investors make decisions to buy new facilities and equipment with certain expectations about how returns will be taxed. Changing investment conditions every few years, or even more frequently, prevents investors from developing a high degree of certainty or confidence about the yields on investments. Achieving a higher level of consistency with regard to private investment decisions could significantly improve the climate for long-term investment in productive assets.

CONCLUSION

In the preceding pages, the Council on Competitiveness has described the dangers posed to the long-term economic vigor of America by undisciplined fiscal policies. The Council also has suggested a two-step agenda that will begin to correct the nation's fiscal problems.

The first, and most critical, component of the agenda is credible, multi-year deficit reduction. This report demonstrates that a consensus between private corporations, labor unions and universities can be developed to get the job done.

The Council recognizes that the four-year spending and revenue program outlined in this report illustrates one way that deficit reduction might be achieved. There are other proposals that will achieve the same goal of cutting the deficit. Some will favor additional revenues, others more spending cuts. The incoming Administration will have its own program as well. The deficit-reduction package put forth by the Council is designed to show both that deficit reduction, if crafted carefully, can support long-term competitiveness and, again, that a consensus exists to get the job done.

The second phase of a pro-competitive fiscal policy involves three actions: making the critical public investments in people, technology and infrastructure to lay solid foundations for economic competitiveness; revalidating the contract between the current work force and the Social Security system by ceasing use of Trust Fund surpluses to mask the deficit; and reexamining and, where necessary, restructuring the tax code to create a more hospitable climate for saving and investment.

The fiscal agenda requires difficult decisions by the President, the Congress and the American people. But our willingness to realistically address these problems today will allow the nation to generate the saving and investment to reclaim the promise of a rising standard of living for future generations.

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ABOUT THE COUNCIL

Founded in 1986, the Council on Competitiveness is an organization of leading executives from industry, organized labor and higher education who have one overriding objective: to improve the ability of American companies and workers to compete in world markets. Among the Council's more specific goals are to increase public awareness of the competitiveness challenge; to promote consensus and cooperation on competitiveness-related issues within the private sector; and to assist in the development of far-sighted government policies that help Americans compete.

The Council is governed by an executive committee and draws on the resources of its national affiliates — more than two dozen trade associations, professional societies and research organizations — to help coordinate private sector activity. The Council is privately supported through contributions from its members, foundations and other granting institutions.

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STATUS OF THE FEDERAL DEPOSIT INSURANCE CORP.

THURSDAY, MARCH 2, 1989

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to notice, at 10:08 a.m., in room SD-608, Dirksen Senate Office Building, the Honorable Jim Sasser (chairman of the committee) presiding.

Present: Senators Sasser, Conrad, Domenici, Armstrong, Grassley, and Kasten.

Staff present: John L. Hilley, staff director; and Jim Carr, assistant director for tax policy and credit.

For the minority: G. William Hoagland, staff director; and Carol Hartwell, assistant staff director and senior analyst for housing and credit.

OPENING STATEMENT OF CHAIRMAN SASSER

Chairman SASSER. The committee will come to order.

We are pleased to welcome before the committee this morning the Federal Deposit Insurance Corporation chairman, Mr. L. William Seidman.

I commend you, Mr. Seidman, for maintaining the public trust and confidence in the banking industry in the face of historic bank failures over the last couple of years. I think the agency under your leadership has been a model of efficient and effective insurance fund management. So, I am pleased to see the FSLIC proposal made by the Bush administration make the FDIC the lead agency in restoring the solvency of the thrift industry insurance fund.

At the close of 1986, the General Accounting Office estimated the Federal Savings and Loan Insurance Corporation to be bankrupt, with a negative net worth of roughly $6 billion. Yet, in the space of 2-short years, we have witnessed, unhappily, a further disintegration of the savings and loan industry and its insurance fund. Now we are told the cost to clean up this financial crisis will cost us over $100 billion.

Throughout most of last year, the Chairman of the Federal Home Loan Bank Board came before the Congress repeatedly with underestimates of the full magnitude of the thrift problem. But I firmly believe that we would be in much better shape today if the Bank Board had been more candid with its estimates of the size of the problem, and told us that they did not have the financial resources to appropriately clean it up.

Yet, instead of asking for further financial assistance, the Bank Board argued that the mergers and acquisitions it was arranging were the least costly deals possible. Today, we know that many of these resolutions were more expensive than liquidations would have been, and that many deals may end up needing to be resolved again later on down the line, at considerable cost to the taxpayer.

Now, the plan put forward to rescue FSLIC by the Bush administration has considerable merits. For one, it recognizes that the cost to liquidate, merge or sell insolvent thrift institutions will exceed $100 billion. Moreover, it recognizes that the Bank Board has entered into financial obligations that exceed the expected financial resources of the S&L fund. And finally, it acknowledges that the responsibilities of the Bank Board, as both regulator and insurer, are basically incompatible.

Perhaps the most positive aspect of the President's plan is the increased fiscal accountability placed on the Federal Deposit Insurance Funds. After all, since FSLIC and FDIC are Federal agencies, their expenditures are reflected on the budget. Under Gramm-Rudman-Hollings limits, every dollar spent by these agencies that exceeds current income is another dollar less that we have to spend on more important or other important priorities.

Therefore, it is essential to have accurate and timely income and expense projections of the FSLIC plan. To the extent that these Federal agencies have the ability to commit taxpayer funds to compensate for their income and reserve shortfalls, it is essential that we have strong and effective budget accountability over such powers.

There are many here in the Congress who feel we must guard against the repeat of the December 1988 situation, where FSLIC was over-committing itself with promissory notes and assistance agreements. These were the agreements that we read about in newspapers and heard about over television as we were celebrating the Christmas holidays, with the Congress far away from Washington.

Here we had a situation where the Bank Board was operating with a blank check and in fact racked up some $17 billion in resolutions in the space of 1 month—and that does not include several billion dollars of tax breaks associated with these resolutions—which are revenue losers which also impact on the bottom line as far as this committee is concerned.

I am supportive of the general intent of the President's plan. I have applauded the President for acting in an expeditious fashion to deal with this whole FSLIC problem. But I do have some concerns about his plan that I would like you to address, Mr. Seidman.

To summarize, I have concerns about Treasury's estimates of the magnitude of the problem. It may be larger than they are projecting. I have doubts about the full extent of the taxpayer participation as painted for us by the Treasury Department. The Treasury's estimates of funding that will be necessary to cover additional costs from previously resolved cases and costs associated with accomplishing the bailout off-budget, I think underestimate the extent of taxpayer liability.

Well, needless to say, I look forward to your observations about these matters, Mr. Seidman. I will turn now, before turning to your testimony, to the distinguished ranking member for any comments or observations he may have for us this morning.

Senator Domenici.

OPENING STATEMENT OF SENATOR DOMENICI

Senator DOMENICI. Thank you very much, Mr. Chairman.

I join in welcoming you here today, Mr. Seidman. I know that you have appeared before several committees lately and you may be growing a little tired of hearing yourself on this issue. Let me reassure you that we do have an interest in your views and, while we do not draw the legislation, it is imperative that we understand its effect.

Yesterday we heard Treasury Secretary Brady. I guess we could use an analogy here. He is perhaps the architect of President Bush's plan, and if he is that, you have an even more serious responsibility. You are going to have to be the builder. You are going to have to be the one that will take that plan and put it together and build it into a new and improved insurance deposit system.

Now, we all recognize that this is a monumental task. The FDIC has been charged with restoring order to the savings and loan industry and confidence to the insurance fund. I do not believe it is an exaggeration, Mr. Seidman, to say that the health of the Nation's financial institutions rides on this effort.

A lot of questions have been raised about the details of the President's plan. By necessity we have to take a broad view, but I believe that we have some very genuine concerns. I have tried to summarize them in three questions: Are we getting the best deal we can for the taxpayers of this country? What will the short- and long-term effect be on the budget? And last but by no means least, will there be sufficient reforms to compensate for this extraordinary infusion of taxpayers money?

A lot of Americans and, I hope, a lot of Senators, when they vote "aye" on the plan, are going to want an answer to that last question. More bluntly, I believe that we are sick and tired of hearing of the abuses in that part of the industry that we are trying to bail out. I am not only speaking of investment abuses, but bookkeeping and audit abuses and also talking about outright fraud.

Now, I do not know how these abuses fit in proportion to the other quantities of this overall problem. But clearly we cannot have a new regulatory scheme that does not assure us that this kind of activity is going to be greatly minimized, if allowed at all.

Now, on the issue of cost, a lot of people are spending a lot of time and energy trying to figure out what the cost is going to be. We have all kinds of numbers, anywhere from $40 to $126 billion. I think these are all legitimate estimates. It just happens that you can figure out cost in different ways, and that is where these numbers come from.

Many are concerned about the reliability of the estimates. It seems to me that is greatly influenced by interest rates in the future and by the level of deposits. We cannot do anything but give best estimates there, and I assume you cannot do any better than that.

I understand these concerns that everyone has. However, I come to the conclusion that we have got to get the best plan and do it. I do not believe we can let the financial system go down the drain. It is not just the S&L's but the whole system that is in jeopardy here.

I do want to close these brief opening remarks with a point of disagreement. I just cannot agree that this ought to be totally off-budget. Before we are finished, I am genuinely interested in hearing your views. But I must submit to you that we ought to get the best interest rates. I am not sure you can get the best interest rates if it is off-budget, unless we make some rare exceptions. If it is going to cost money—and, I regret to say, everybody has told us it is—I do not know why it ought to be higher than necessary. I mean maybe you just want to account for the costs off-budget, but somehow or another we have to have an overview of this as part of the unified budget of the United States.

I am not one that wants to argue about OMB having control over your fund. I am not even prepared to argue whether a sequester should apply. I have gone through that issue and it does not make tremendous sense to me to sequester the assets of your fund. But that does not mean that this whole activity ought to be off-budget. So I hope we can get that at least understood. I will give you more of my views in specific questions later on.

Thank you, Mr. Chairman.

Chairman SASSER. Thank you, Senator Domenici.

Mr. Seidman, we will turn to you now for your comments or statement.

STATEMENT OF L. WILLIAM SEIDMAN, CHAIRMAN, FEDERAL DEPOSIT INSURANCE CORPORATION

Mr. SEIDMAN. Thank you, Mr. Chairman, and thank you for your kind comments, Senator Domenici and Senator Armstrong.

I am pleased to be here today to talk about what I agree is one very serious problem that can affect the entire financial system of the United States.

The FDIC supports the President's recently proposed legislation that was introduced as S. 413. We believe its financial estimates are realistic and the restructuring proposal is sound.

Let me just say with respect to restructuring, as you may have seen, we did a year-long study on restructuring which we have just presented. We have copies of that for you and your staff, which will provide some background on the FDIC's views on many issues.

Moving to the size of the problem, in order to assess the budgetary implications of the thrift problem, it is critical to ascertain the size of the loss. At the beginning of 1988, there were approximately 500 insolvent thrifts under generally accepted accounting principles with assets of over $200 billion. During 1988, the Bank Board took action on more than 200 S&L's, at a reported cost of over $39 billion on a present value basis.

As of the end of the third quarter of 1988, there were about 220 thrifts that were insolvent under regulatory accounting principles, not including the ones previously handled, and another 119 were insolvent under regular or GAAP accounting principles. In addition, there would be approximately another 100 insolvent S&L's if banking standards were used, namely, if goodwill were eliminated. Our latest estimates suggest that current operating losses at RAP and GAAP insolvent S&L's are about $200 million per month. That figure will be higher as interest rates rise or as S&Ls experience unusual deposit outflows, as they have recently, the S&L's must fund with higher cost deposits.

We have stated in the past, and would like to repeat, that reliable cost estimates of resolving the insolvent S&L's should be made by on-site examinations. We are in the process of making such estimates pursuant to the joint oversight effort discussed in our written testimony. We should be able to report on these on-site examinations within the next 6 weeks.

We understand that the GAO will release a cost analysis of S&L transactions previously done by the Bank Board. The GAO report and the completion of our on-site examinations will give us further information, and I would say the best information, on the actual size of the loss. Our best estimates at this time are in the same range as Treasury's estimated cost, providing economic conditions do not worsen and assuming the accuracy of the $39 billion estimated cost of S&L transactions completed by the Bank Board. We have not examined those transactions, so we do not know whether that number is accurate or not.

We have supplied you with estimates of loss for various groups of S&L's in our written testimony in Chart A.

The President's financing proposal: The Bush reform plan financing package was drawn up by Treasury and OMB and they are in the best position to comment on it. From our viewpoint, the plan appears viable and sound, providing for an equitable sharing of the financial burden between the S&L industry and Treasury. Chart C in our written statement depicts the President's financial plan, and Chart D is a diagram of a more direct financing approach that we developed at the request of Senator Riegle for the Banking Committee hearing earlier this week.

One part of the President's proposal calls for increased insurance premiums for both banks and S&L's. The increased premium for the S&L's will be used to partially offset the cost of the industry's problems. The banks 'increased premiums will be used to strengthen the FDIC insurance fund, but, as is appropriate, that revenue will not be used for S&L losses. However, both premium increases will add to general Federal revenues for budgetary purposes.

We support the President's proposal to increase assessment rates for banks. Those increases should not pose an unreasonable burden on the banking system. Use of variable premiums to reflect the fund's experience was recommended in our study, "Deposit Insurance for the Nineties," which I mentioned previously.

The FDIC would have recommended such an increase in bank premiums without regard to the S&L problem.

As to the proposed increased premiums on S&L's, the thrift industry should shoulder as much of the burden of the industry's problems as it can. We believe the rates proposed by the President are reasonable. However, there should be careful consideration of the effect of the premium levels on the industry's viability, when coupled with significant increased capital requirements, goodwill writeoffs and the loss of income from the Federal Home Loan Bank

System. Thus, we believe that this complex question requires that flexible authority be provided to the insurer.

In an ideal world, insurance trust funds should be separately budgeted, in our view, and should not be part of the general operation of the Federal budget. They should be budgeted, but they should be budgeted separately, because of the difference in their purpose. Even though this is not a part of the President's proposal—and we are not criticizing the fact that it was omitted—we raise this as a long-term objective, since it is within the committee's jurisdiction.

The purpose of insurance funds is to save for emergencies. While the funds receive no taxpayer dollars, unspent premium income is deposited with the Treasury and counted as income to the government. When funds are withdrawn to deal with a problem institution, that action is treated as a government expenditure. Instead, it really should be treated as a payback of money on deposit.

Thus, under the current system, there is a disincentive for saving for future problems and a hesitancy to draw on funds to deal with industry problems at an early stage, when costs may well be lower. So, we believe long-term that this committee ought to talk about not off-budget, but a separate budget handled in the same way. Then, if macro-economists want to add them together to look at other effects, they can do so. We would recommend that the committee consider that in the longer term.

In conclusion, while we know this committee is acutely aware of the need for expeditious legislative action, we want to stress that point. Nothing of major substance can be accomplished to correct the S&L problem until Congress acts to provide funding and guidance. I think that in practically every State of the Union there are situations which are crying to be dealt with. I am sure that every Senator and Congressman will be hearing from people asking us to do something, and our reply to them has to be we are unable to do anything to hold the fort until Congress acts.

Thank you very much.

Chairman SASSER. Thank you very much, Mr. Seidman.

[The prepared statement of Mr. Seidman follows:]

TESTIMONY OF

L. WILLIAM SEIDMAN
CHAIRMAN
FEDERAL DEPOSIT INSURANCE CORPORATION
WASHINGTON, D.C.

ON

THE SAVINGS AND LOAN INDUSTRY AND THE FEDERAL SAVINGS AND LOAN INSURANCE CORPORATION

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

10:00 a.m.
March 2, 1989

Good morning, Mr. Chairman and members of the Committee. I am pleased to testify today on the current problems of the savings and loan ("S&L") industry and the Federal Savings and Loan Insurance Corporation ("FSLIC"). As requested in the Committee's letter of invitation, our testimony today will focus on the costs involved in resolving the S&L situation.

The Federal Deposit Insurance Corporation ("FDIC") generally supports President Bush's Reform Plan for the S&L industry, announced February 6th, and the recently proposed legislation -- that was introduced last week as S. 413 -- to carry out that plan. We believe it is a sound, constructive and farsighted proposal that should be enacted. S. 413 provides for prompt action to resolve the S&L situation and proposes structural and regulatory reforms designed to make the federal deposit insurance system cost-effective.

BACKGROUND

The FDIC has had firsthand experience dealing with many problems similar to those faced by the thrifts and the FSLIC. These include high and volatile interest rates, increased competition from nonbank providers of financial services, a boom-to-bust economy in the Southwest, and fraud and insider abuse.

These adverse conditions have contributed to the record number of bank failures over the past several years. In 1988 alone, the FDIC fund dealt with $80 billion of problem bank assets -- more than the combined total of assets handled during its first fifty years. As a result, the insurance fund declined from over $18 billion to approximately $14 billion -- our first operating loss ever.

Concern over the high cost of providing deposit insurance led the FDIC to undertake a year-long review of ways to improve the current deposit insurance system. Our recently released study, Deposit Insurance for the Nineties: Meeting the Challenge, contains recommendations for reforming the deposit insurance system and provides an outline for a restructured federal deposit insurance system. I would like to submit the executive summary of our study for the record. As part of our review, we studied the size and estimated cost of the thrift problem, and analyzed alternative funding sources.

SIZE OF THE PROBLEM

In order to estimate fully the budgetary implications of the thrift problem, ascertaining the size of the insurance loss is critical. At the beginning of 1988, there were approximately 500 insolvent thrifts under generally accepted accounting principles ("GAAP") with assets over $200 billion. During 1988, the Federal Home Loan Bank Board ("FHLBB") took action on more than 200 S&Ls at a reported cost of over $39 billion on a present value basis. We understand that the General Accounting Office ("GAO") soon will release a cost analysis of S&L transactions during 1988.

As of the end of the third quarter of 1988, there were about 220 thrifts that were insolvent under regulatory accounting principles ("RAP"), not including those thrifts handled by the FHLBB in 1988, and another 119 GAAP insolvent thrifts. In addition, there would be another 100 insolvent S&Ls under banking standards -- namely, if goodwill were eliminated. Our latest estimates suggest that current operating losses at these RAP and GAAP insolvent S&Ls are about $200 million per month. That figure will be higher if S&Ls experience deposit outflows, as they have recently, and must fund with higher cost deposits.

We have stated in the past that reliable cost estimates of resolving the insolvent S&Ls should be made by on-site examinations. We are in the process of making such estimates pursuant to the joint oversight effort discussed below. Once our estimates are completed and GAO has issued its report on the cost of the FSLIC's S&L transactions in 1988, we will have a more accurate total estimate of the S&L situation. Our best estimates at this time are in the same range as the Treasury Department's estimated costs. See the attached Charts A and B.

When discussing cost figures, it is important not to confuse present value with actual dollars spent over the life of the workout. Charts A and B provide information on those cost figures. The present value is the appropriate figure to focus on -- it represents the cost in today's dollars. The actual dollar figure mixes apples and oranges because a dollar spent in the future is worth less than a dollar today.

For example, consider buying a house that sells for $100,000. One could either pay cash or finance it. If the purchase is financed with, say, a 30-year fixed rate mortgage at 10 percent annual rate, the monthly payment will be approximately $875. Over the thirty years, the payments add up to $316,000. Even though the person who finances the house outlays, over the life of the mortgage, more than three times the number of dollars than the person who pays cash, we do not say that the house costs three time as much for people who finance.

The cost estimate which is projected by the President's proposal is based on today's dollars. If the rescue plan is financed, the actual dollars outlayed will be substantially higher than that amount, but the cost will not be.

BUSH REFORM PLAN FINANCING PROPOSAL

The Treasury Department and the Office of Management and Budget are the architects of the financing provisions of S. 413, and thus are in the best position to comment on them. From our viewpoint the financing plan, while complex, appears viable and sound. The attached Chart C provides information on the sources and uses of funds under the proposed financing plan. Chart D is a diagram of a more direct financing approach that we developed at the request of Senator Riegle for the Banking Committee hearing earlier this week.

Ability of banks and S&Ls to pay increased premiums. In general, we believe S. 413 provides for an equitable sharing of the financial burden between the S&L industry and the Treasury. Appropriately, banks are not required to pay for the S&L losses.

The bill would impose increased insurance premiums for both banks and S&Ls. The increased premiums for the S&Ls will be used to partially offset the cost of that industry's problems. The banks' increased premiums will be used to strengthen the FDIC insurance fund. Both premium increases will add to general federal revenues for budgetary purposes.

In our recently released study on deposit insurance, we concluded that FDIC deposit insurance premiums should be adjusted for the risk and costs incurred by the insurance fund. The FDIC spent $7 billion dollars last year, and our fund declined by about $4 billion, or over 20 percent. Our fund's reserves at year-end will be reduced to 83 cents per $100 of insured deposits, well below desired levels. Without regard to the S&L industry problems, the FDIC study recommended that bank premium rates be increased to reflect more accurately recent loss experience of the FDIC fund.

The Bush Reform Plan calls for such an increase -- and we support this proposal. Raising bank premiums from their current level of 8.33 basis points to 12 basis points next year, and then 15 basis points the year after, is reasonable. We estimate going to 12 basis points will increase premiums about $700 million, and that 15 basis points will bring in almost $600 million more.

The increase in premium expenses translates to about 2.1 percent and 3.8 percent of pre-tax earnings at 12 and 15 basis points, respectively. To some extent, this increase probably could be offset by repricing of services, but the ability to do this is constrained by today's competitive market place. Assuming that all the increase resulted in earnings reductions, we estimate that fewer than 100 institutions out of over 13,000 that are now profitable would be made unprofitable.

The majority of the banks that would suffer the most significant decline in profitability from higher assessments are located in the Southwest and Midwest regions, the two regions that have experienced the greatest difficulties during this decade.

Given recent FDIC loss experience, the increases are consistent with our study's conclusions and should not pose an unreasonable burden to the banking system. Importantly, the revenues generated from these premiums will go solely to build the bank insurance fund of the restructured FDIC.

Under S. 413, once the bank fund moves up from .8 to 1.25 percent of insured deposits, banks can expect premium rebates. Our preliminary estimate is that rebates could begin as early as the mid-1990s under the President's plan.

We recently completed an evaluation of the rebates the FDIC paid from 1950 through the early eighties. We added all rebates from that period back into our fund and applied the yield we would have earned on those funds. We discovered that, if no rebates had been paid during that time, the FDIC today would have another $26 billion in its insurance fund

This indicates that the current rate of 8 basis points was more than sufficient to meet costs if no rebates had been paid. Thus, a return to lower premiums may be indicated at some future date.

As to the proposed increased premiums on the thrift industry, the thrift industry should shoulder as much of the burden of the industry's problems as possible. Since increased premiums affect profitability, and potentially even solvency, it is important to the insurer to levy rates that will leave the S&L industry viable -- and not drive more institutions into the federal safety net. In fact, there should be careful consideration of the effect of the premium level on the industry's viability when coupled with the significantly increased capital requirements, goodwill write-off and the loss of income from the FHLB System. This is a complex question which requires that flexibile authority be provided to the insurer.

INTERAGENCY OVERSIGHT EFFORT

As part of the Bush Reform Plan, the President recently requested that the FDIC lead a joint effort to evaluate and oversee most of the RAP insolvent thrifts. In addition to the FDIC and the FSLIC, the Federal Home Loan Bank Board, the Federal Reserve, and the Office of the Comptroller of the Currency are participating in this interagency initiative.

The purpose of this interagency effort is to limit the growth of problems in our nation's insolvent thrifts until a comprehensive reform of the deposit insurance system, and the necessary funding, are authorized by the Congress. Insured deposits will remain fully protected throughout this process.

Since the program was announced by President Bush on February 6th, a joint task force of regulators, led by the FDIC, has taken control of 36 of the RAP insolvent thrifts. We are going into another 37 today and expect to assume oversight of the rest of the over 200 RAP insolvent thrifts in the next four-to-six weeks.

The FSLIC has contracted with the FDIC to take control of these institutions that are being placed in conservatorship or receivership. That means the FDIC, with the help of other regulators, will oversee operations of the insolvent thrifts. Managements of the various institutions are subject to the regulators' authority. From the customer's perspective, however, the only visible difference will be a few more people in the institution's offices. Day-to-day operations will continue to preserve basic services to deposit and loan customers.

One of the first priorities of these oversight efforts will be to evaluate the losses at each institution. Such on-site examinations are necessary to produce accurate estimates of the cost of the thrift problem. As already noted, once our estimates are completed and GAO has issued its report on the cost of FSLIC's 1988 deals, the total cost of this problem can be determined more accurately.

Another top priority is to identify and stop any abuse, waste, or fraud that may be present. A further priority will be to prepare a business plan for the institution and seek cost reduction through consolidations and more efficient operations.

While in control of these institutions, we will seek to stop any unsafe or unsound practices. We will limit their growth, and downsize them through asset liquidations where possible. However, we will avoid firesales of assets and emphasize the need to sell at values that reflect current appraised values.

Finally, we will develop longer-term solutions to these problems. Our staff will recommend different approaches -- from liquidating the institutions to selling them to qualified purchasers. But our current job is a holding action only. We will not issue notes or enter into income maintenance agreements.

The FDIC has established four task groups to address these responsibilities. These task groups are designed to ensure stable operations in the insolvent thrifts and to evaluate options for permanently resolving their insolvency once funding is approved by Congress.

One of our most important task groups is our new Fraud Squad. As President Bush has said, "unconscionable risk-taking, fraud and outright criminality have also been factors [in the thrift problem]." Investigators assigned to this Fraud Squad will constitute a mobile unit. Whenever our on-site teams discover evidence that fraud or insider abuse may have occurred, the Squad will be sent to conduct a full-scale investigation. This includes looking for ways to get back misappropriated assets when possible, and helping send some to jail when appropriate.

Our three other task groups have separate but complementary assignments.

Our Oversight and Evaluation task group will examine these institutions' condition, provide guidance to these institutions, and take steps to reduce operating costs where possible.

Our Planning and Restructuring task group will recommend steps to restructure and consolidate institutions where appropriate.

And our Transaction and Acquisition task group will begin the process of seeking out buyers for institutions, real estate and other assets. We will seek to reach agreements with purchasers subject to resources being made available to provide assistance.

The FDIC and the FHLBB have agreed that, until the agencies review the status of the insolvent thrift institutions placed under joint regulatory oversight, only cash assistance transactions will be undertaken by the FSLIC.

We also must note that these additional responsibilities in addressing the S&L situation will place a strain on FDIC resources. We are dedicated to this new task and will strive for success, but we do expect to experience growing pains and recognize our need to climb a learning curve in the process.

RECOMMENDED DEPOSIT INSURANCE REFORMS

Any legislated resolution of the FSLIC problem, in addition to providing appropriate funding, should reform the system to protect against recurrence of the problems that led to the current S&L situation. As mentioned above, detailed recommendations for improvements to the system are contained in the recent FDIC study. We would like to highlight, however, two needed improvements.

Separate budget. One concept contained in the study, within the jurisdiction of this Committee, is that the FSLIC and FDIC insurance funds should be separately budgeted and should not be part of the general operational federal budget. In essence, the basic purpose and mandate of the funds is to save for emergencies. For decades the insurance funds have been depositing their unspent premium income into the U.S. Treasury. While the insurance trust funds receive no taxpayer dollars, these deposits to the Treasury nonetheless are counted as income to the government rather than savings reserved for future problems in the industry. When funds are withdrawn from the Treasury to deal with a problem institution, that action is treated as a government expenditure. Instead, it should be treated as a payback of money on deposit.

As the present system is designed, it creates a disincentive for saving for future problems. Moreover, because of the immediate negative impact on the general budget, the insurer may be hesitant to draw upon funds to deal with industry problems at an early stage.

For these reasons, we urge the Committee to consider setting up a separate budget for the deposit insurance funds. The President's plan does not provide for such a separate budget.

Independence of the Insurer. Another fundamental change recommended in our study is that the federal insurer be allowed to operate as much as possible like an independent private insurer. Although the President's proposed legislation provides for progress in the independence of the former FSLIC, certain provisions of the plan run counter to the principle of establishing an independent deposit insurer. In fact, in each of the following instances, the legislation would make changes to the existing independence of the FDIC that would limit its independence.

First, the bill would permit the President to appoint and remove, with or without cause, the Chairman and Vice Chairman of the reconstituted FDIC Board of Directors. At present, the Board of the FDIC elects its Chairman. We believe such removal authority could compromise significantly the independence of the FDIC, and recommend that it be deleted. If a change is needed, we would suggest that a system similar to the Federal Reserve System -- appointment for a term with the consent of the Senate -- be adopted.

Second, another provision of S. 413 would place limits on the FDIC's borrowing authority. We believe it is appropriate to limit the FDIC's ability to issue notes and other debt obligations. However, the proposed limitations are impractical and overly restrictive and could seriously undermine the safe and cost-effective operations of the insurer in the near term.

To put the proposed limit in perspective, it would restrict the FDIC's obligations to $7 billion. We are almost at the proposed cap already. Currently the FDIC has about $6 billion in obligations. In each case the liability was properly recorded with the appropriate charge taken against net worth.

The FDIC's $14 billion of net worth represents the unencumbered assets available in excess of that needed to satisfy all actual and contingent liabilities. In other words, the FDIC has not used debt because it does not have the necessary resources, but because of other valid business reasons. Examples of such reasons include providing failed bank acquirors additional flexibility in markets with weak loan demand, avoiding untimely portfolio sales and even maintaining some additional leverage to ensure buyers hold up their end of the bargain.

Thus, instead, we recommend a very simple borrowing limit: No notes can be issued which will put the agency into a deficit net worth position. Thus, the FDIC would be able to obligate neither itself nor the general government revenues in an amount beyond the limits of the FDIC's resources as determined by GAO audit. By imposing the limit that we recommend, the insurer could not issue debt if it does not have its own resources to repay that debt and, thus, could not obligate taxpayer funds.

Third, S. 413 would require the FDIC to submit quarterly reports to both the Secretary of the Treasury and the Director of the Office of Management and Budget on the FDIC's financial operating plans and forecasts. We believe it should be sufficient to file such reports with the Administration through the Treasury and that the reports should be those prepared by the FDIC in the ordinary course of its business.

CONCLUSION

In conclusion, while we know this Committee is acutely aware of the need for expeditious legislative action, we want to stress that point. Nothing of major substance can be accomplished to correct this problem until the Congress acts to provide funding and guidance.

We believe S. 413 is a sound bill, and hope Congress acts on it promptly. We would be happy to work with the Committee on any aspect of the S&L situation where we may be helpful. I would be pleased, at this time, to answer any questions the Committee may have.

Attachments

CHART A

3rd QUARTER SUMMARY SHEET DATA ON FINANCIAL TROUBLED S&Ls ($BILLIONS)

S&L Group	NO.	Total Assets	Total Liab.	Annual Income	Est. Cost #1	Cost To Assets	Est. Cost #2	Cost To Assets
Handled by FSLIC in 1988	200	$103.2	$120.1	$-10.2	$38.9	.38	$42.9	.42
Other:								
RAP - Insolvent & Unprofitable	217	$56.9	$65.6	$-5.3	$22.8	.40	$25.0	.44
RAP - Insolvent & Profitable	5	$2.5	$2.5	$0.0	$0.4	.16	0.6	.24
SUBTOTAL	430	$162.6	$188.2	$-15.5	$62.1	.38	$67.9	.42
RAP Solvent but GAAP - insolvent & unprofitable	72	$24.2	$23.7	$-0.3	$3.6	.15	$4.8	.20
RAP - Solvent but GAAP - insolvent & profitable	45	$12.1	$11.7	$0.3	$1.6	.13	$2.2	.18
SUBTOTAL	547	$198.9	$223.6	$-15.5	$67.3	.34	$74.9	.38
RAP & GAAP - solvent but tangible insolvent and unprofitable	69	$55.1	$53.2	$-0.5	$8.3	.15	$10.9	.20
RAP & GAAP solvent but tangible - insolvent and profitable	52	$66.4	$63.5	$0.2	$6.8	.10	$10.9	.16
SUBTOTAL	668	320.4	$340.3	$-15.8	$82.4	.26	$96.7	.30
Marginally solvent but unprofitable	154	$101.1	97.6	$-0.7	$9.6	.09	$14.9	.15
TOTAL	882	$421.5	$437.9	$-16.5	$92.00	.22	$111.6	.26

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[1] Estimated Cost #1 :Failed-bank cost formula with zero loss assigned to residential mortgages and pass-through securities.

[2] Estimated Cost #2 :Failed -bank cost formula with 10% loss assigned to residential mortgages and mortgage pass-through securities.

CHART B

ADMINISTRATION'S FINANCING PROPOSAL*
(in billions of dollars)

Time to Maturity

Interest Rate	10 years	20 years	30 years
2%	100-125	115-140	125-150
4%	115-140	135-165	160-200
6%	125-160	160-200	200-250
8%	140-170	190-230	250-300
10%	150-180	215-265	300-350

*Cash flows represent actual dollars spent if net present value cost of $90-110 billion is financed over different time periods at interest rates shown in chart.

CHART C

ADMINISTRATION'S FINANCING PROPOSAL

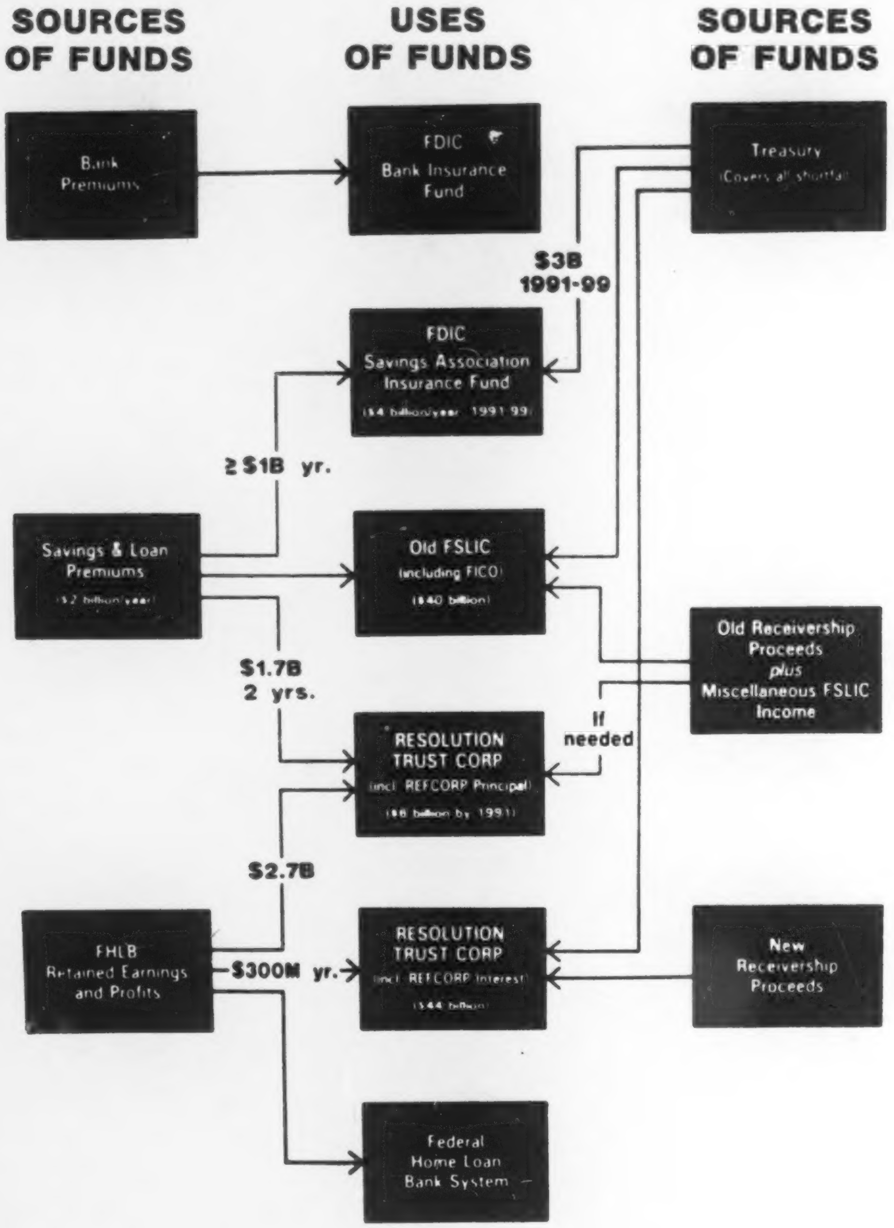
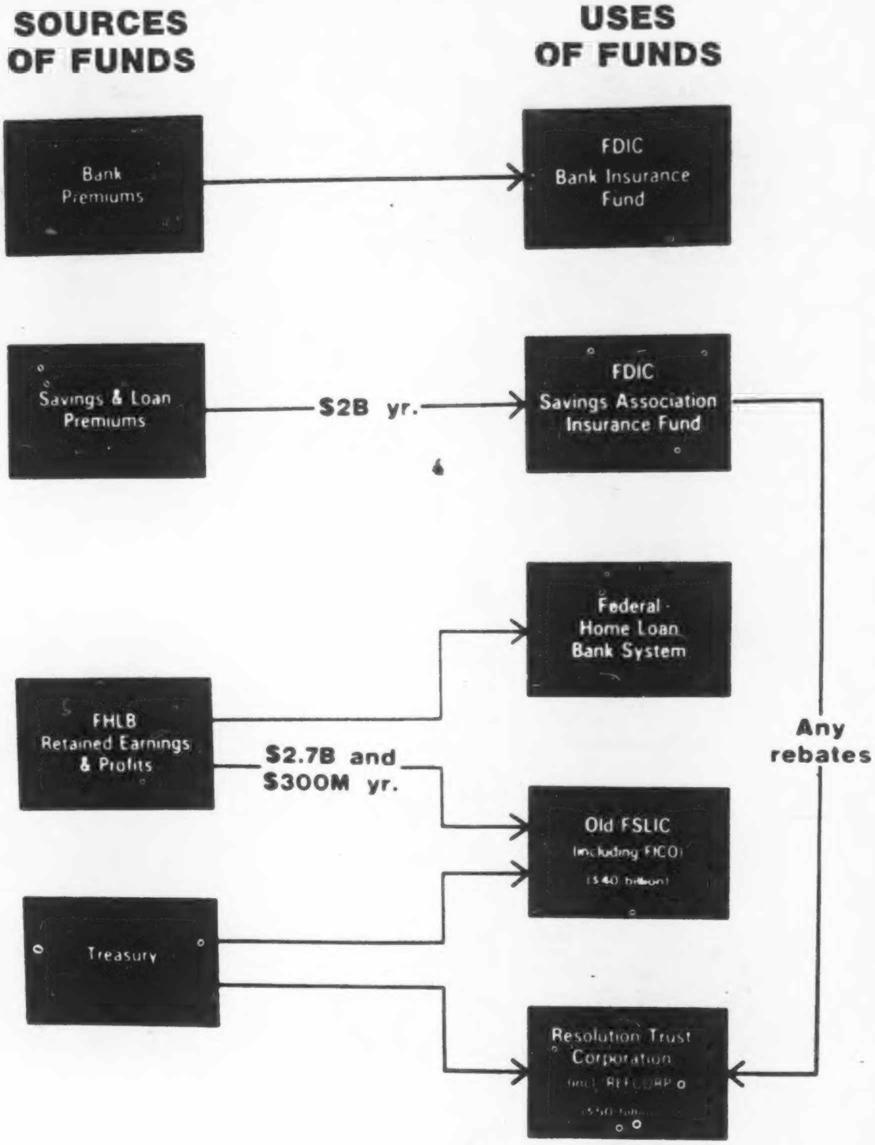

SOURCES OF FUNDS
USES OF FUNDS
SOURCES OF FUNDS
Bank Premiums
FDIC Bank Insurance Fund
Treasury (Covers all shortfall)
$3B 1991-99
FDIC Savings Association Insurance Fund ($4 billion/year 1991-99)
≥ $1B yr.
Savings & Loan Premiums ($2 billion/year)
Old FSLIC (including FICO) ($40 billion)
Old Receivership Proceeds *plus* Miscellaneous FSLIC Income
$1.7B 2 yrs.
If needed
RESOLUTION TRUST CORP (incl. REFCORP Principal) ($8 billion by 1991)
$2.7B
FHLB Retained Earnings and Profits
$300M yr.
RESOLUTION TRUST CORP (incl. REFCORP Interest) ($44 billion)
New Receivership Proceeds
Federal Home Loan Bank System

CHART D

ALTERNATIVE FINANCING PROPOSAL


SOURCES OF FUNDS
USES OF FUNDS
Bank Premiums
FDIC Bank Insurance Fund
Savings & Loan Premiums
$2B yr.
FDIC Savings Association Insurance Fund
Federal Home Loan Bank System
FHLB Retained Earnings & Profits
$2.7B and $300M yr.
Old FSLIC (including FICO) ($40 billion)
Any rebates
Treasury
Resolution Trust Corporation (incl. REFCORP) ($50 billion)

Chairman SASSER. Let me ask you just a few questions about the plan. As I said earlier, I think in the main the administration is to be commended for moving forward expeditiously to deal with what is perhaps one of the most serious problems we have had in the financial services industry since the Great Depression days of the thirties.

There seem to be some inconsistencies in the plan, and I want to get your comments on them. For example, the Treasury plan assumes deposit growth in the savings and loan industry to climb to about 7.2 percent on an annual basis. Now, we are just anticipating deposit growth in the commercial banking industry to grow at the rate of 6.9 percent annually, according to the figures that I have seen.

With all of the front-page publicity that FSLIC has been getting lately, we have seen near-record withdrawal rates coming out of the S&L's. For example, in November of 1988, there was $7 billion coming out, in December of 1988, there was an $8 billion loss in deposits, and just yesterday the Bank Board indicated that the thrift industry has experienced net withdrawals of $12.2 billion since the start of this year. Now, that does not indicate that there has been a run on deposits, but it does indicate that it is going to take a lot of growth in deposits just to make up for this drain that has taken place in the system.

So, on the one hand, you have got the administration predicting you are going to have 7.2-percent growth in deposits in the S&L industry, out-pacing the growth in deposits in the commercial banking industry. At the same time, we have got this drain on deposits in the S&L industry taking place right now.

As I read the Treasury plan, it contains incentives to encourage lower rates on deposits, and this is going to shrink the deposit base in the S&L industry, it appears to me, even further. I understand why they have these incentives to encourage lower rates on deposits, because as you know and I know, the current crisis really came about partly as a result of rapid deposit growth that came from the high-fliers who were offering these exorbitant rates.

But we come back to what appears to me to be contradictory assumptions. In other words, we think the S&L deposit base is going to grow faster than commercial banks, while at the same time we are seeing deposits flowing out. Your answer to that may be, after we get it stabilized, that you think the deposits will come back in. But at the same time that we are imposing these incentives on the S&L's which will make them pay less, a lower rate on deposits will be less attractive for additional deposits.

What about these contradictory assumptions? Do you think it is realistic to assume a 7.2-percent growth rate of deposits in the S&L industry?

Mr. SEIDMAN. Mr. Chairman, if you look at historical growth, one would say that that is a reasonable estimate. On the other hand, there has been growth in that industry, just because they have been in trouble and because they have been paying these high rates.

Looking ahead, I think once the industry is stabilized and it returns to being an industry in which people have confidence, deposits will grow. How one can be sure they will grow at 7 percent, I do not know. It may well be that in the early years they will not be able to achieve that. In the longer run, I would expect that their growth rate would be comparable to banks.

Chairman SASSER. Do you have a feeling as to how much assessment income for FSLIC might decline if the growth rate, instead of being 7.2 percent, was 3.5 percent or 4 percent?

Mr. SEIDMAN. Well, it will cut that estimate by the premium rate, which is .23, and in the overall estimate it will be a relatively small amount compared to the total amount which is being paid, which is on all deposits. I do not have those numbers with me, but we can supply them to you.

Chairman SASSER. So, I suppose what you are saying is if the growth rate is half of what is being projected, it is not going to be that big a deal anyway. Is that how I read your answer?

Mr. SEIDMAN. Yes, that is correct. Obviously, it will cost the Treasury more money, but it is not going to be a very substantial amount in the total picture.

Chairman SASSER. Do we have any estimate on how much it might be?

Mr. SEIDMAN. I do not have it with me. I would be glad to supply you with a chart and show exactly how it would be at various levels of deposit growth.

Chairman SASSER. Well, if you would do that, that would be a big help, and I would very much appreciate it.

Mr. SEIDMAN. I will supply that.

[The following was subsequently supplied for the record by Mr. Seidman:]

S & L ASSESSMENT REVENUES UNDER THE BUSH PLAN
(Assuming 7.2% Annual Growth in Assessment Base)*
(all values in millions of dollars)

Year	Assessment Rate (BP)	Assessment Base	Assessment Revenues
1990	20.8	$1,111,824	$2,313
1991	23	1,191,876	2,741
1992	23	1,277,691	2,939
1993	23	1,369,685	3,150
1994	18	,468,302	2,643
1995	18	1,574,020	2,833
1996	18	1,687,349	3,037
1997	18	1,808,838	3,256
1998	18	1,939,074	3,490
1999	18	2,078,688	3,741
TOTAL			30,143

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* Assessment base = all deposits

S & L ASSESSMENT REVENUES UNDER THE BUSH PLAN
(Assuming 3.6% Annual Growth in Assessment Base)*
(all values in millions of dollars)

Year	Assessment Rate (BP)	Assessment Base	Revenues
1990	20.8	$1,038,404	$2,160
1991	23	1,075,786	2,474
1992	23	1,114,514	2,563
1993	23	1,154,637	3,656
1994	18	1,196,204	2,153
1995	18	1,239,267	2,231
1996	18	1,283,881	2,311
1997	18	1,330,101	2,394
1998	18	1,377,984	2,480
1999	18	1,429,592	2,570
TOTAL			23,992

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* Assessment base = all deposits

S & L ASSESSMENT REVENUES UNDER THE BUSH PLAN
(Assuming 7.2% Annual Growth in Assessment Base)*
(all values in millions of dollars)

Year	Assessment Rate (BP)	Assessment Base	Assessment Revenues
1990	20.8	$1,284,838	$2,672
1991	23	1,377,346	3,168
1992	23	1,476,515	3,396
1993	23	1,582,824	3,640
1994	18	1,696,787	3,054
1995	18	1,818,956	3,274
1996	18	1,949,921	3,510
1997	18	2,090,315	3,763
1998	18	2,240,818	4.033
1999	18	2,402,156	4,324
TOTAL			34,834

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* Assessment base = all deposits plus collateralized borrowings (excluding repurchase agreements).

S & L ASSESSMENT REVENUES UNDER THE BUSH PLAN
(Assuming 3.6% Annual Growth in Assessment Base)*
(all values in millions of dollars)

Year	Assessment Rate (BP)	Assessment Base	Assessment Revenues
1990	20.8	$1,199,991	$2,496
1991	23	1,243,191	2,859
1992	23	1,287,946	2,962
1993	23	1,334,312	3,069
1994	18	1,382,347	2,488
1995	18	1,432,112	2,578
1996	18	1,483,668	2,671
1997	18	1,537,080	2,767
1998	18	1,592,415	2,866
1999	18	1,649,742	2,970
TOTAL			27,726

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* Assessment base = all deposits plus collateralized borrowings (excluding repurchase agreements).

Chairman **Sasser**. The current estimate on the cost of the deals arranged by FSLIC last year that caused so much heartburn among Members of Congress and many other people is $40 billion. Now, that estimate was calculated when interest rates were lower than those that we are experiencing now under the Federal Reserve's aggressive anti-inflationary stance.

Is it possible that the $40 billion estimate understates the cost of last year's deals, considering today's climbing interest rates, Mr. Seidman? And is it not true that—I think it is a given, really—that these three institutions are extremely sensitive to even relatively modest interest rate fluctuations?

Mr. **Seidman**. It is clear that the kind of arrangements that the Bank Board was using at that time are very interest-rate sensitive. I understand, although I have not seen them myself, they have not been furnished to us, that the basic approach was to provide income maintenance for a substantial portion of all the assets in the institutions which were dealt with.

Under income maintenance, when rates go up, the government makes up the difference to maintain the same level of income. Therefore, they are directly related to the interest rate. If they did $60 billion of those, which is one estimate, the cost would go up $600 million a year for each percent of interest rate increase, as a general look at those types of contracts.

Since the government's provision of funds is tax-free to the institutions, of course, there is no revenue regaining on the other side through the tax laws.

Chairman **Sasser**. Just one short follow-up question, although my time has expired. Are you satisfied with the Administration's interest rate assumptions in this plan, in light of the fact that rates are going up and the Fed chairman is indicating he is going to keep a stiff upper lip with regard to inflation and give us the bitter medicine here if we do not cut this deficit?

Mr. **Seidman**. Well we did not participate in the preparation of the plan or the interest rates, so we have made no particular study of that. I really do not have any reason to question it, although it is clear that at the moment interest rates are going up and may be higher than those assumed in the plan.

Chairman **Sasser**. I just might say as an aside that this morning I made a speech to the American Bankers Association, who had about 500 bankers in town, and they were asking me about the plan and wanted to know about the interest rate assumption, and I said they were based on 5.5 percent, 90-day T bills, and the room shook with laughter.

Senator Domenici?

Senator **Domenici**. I might say to the distinguished Chairman, I do not know whether deposits are going to go up or down, but I think there is a bit of reason for optimism. We are very concerned as a Nation about savings rates, and I note that the personal savings as a percentage of disposable personal income has steadily risen since 1987. The last estimate, for January 1988, is 5.8 percent, up from 4.8 in December I am not sure it is going to turn out exactly that large an increase when we do the final calculations. Nor do I know that a big percentage is not going to drop off the savings and loans and go somewhere else. But it does seem to me we are on the right track. Cumulative personal savings are going up and that means we ought to get this taken care of quickly so we can have credibility.

Let me make sure you understand my position regarding this whole notion of budgeting. Frankly, I think the paramount thing we ought to be looking for is the best possible plan at the lowest possible cost to the taxpayers, as far as the finance package. Then we ought to look at the best set of regulations that are humanly possible and the best assignment of authority to those regulators to see that we get the best kind of management once [we have done this.

Now, having said that, I just have a general question. Maybe you are not equipped to talk about some of the "budgetese," which is kind of esoteric sometimes, but I want to put it in the reverse. Do you see anything in the plan proposed by the President through the Secretary of the Treasury that might have been arrived at for budget reasons that might not be the very best from the standpoint of the plan? And if you do not know that, I——

Mr. SEIDMAN. Well, I can only comment that in the hearings with Senator Riegle, they estimated that by having this financing not be direct Treasury obligations, there would be an increase in cost of somewhere between 25 and 40 basis points. Therefore, I think that that is a fact. Whether it is appropriate or not, it comes into the whole budgeting process is a matter of judgment. However, I think it is clear that the cost will be less if it is direct Treasury financing.

Senator DOMENICI. Aside from budgetary impact, is there any negative that you know of to being Treasury financed versus the manner recommended, in macroeconomic terms or otherwise?

Mr. SEIDMAN. I do not know of any reason, no.

Senator DOMENICI. It seems to me when we talk about this kind of a reorganization, that we ought to start with a very fundamental question. I have certainly heard the answers, but I just think it would be good to put it on the record. Do we need a separate thrift industry and will the S&L's be limited to mortgage lending under the administration's plan? What is the justification for maintaining a separate thrift industry with diversified powers? Inherent in that is the notion of housing lenders, and I think that has been a marvelous success story in America. I am just wondering if there is any shortage of capital in that area that the thrifts fill?

Mr. SEIDMAN. Our view, Senator, is that if you were starting with a clean slate today, you might not have a separate thrift industry. You might have some banks that specialize in housing. However, we do have a thrift industry out there. Two-thirds of it is viable and some of it is very prosperous. They are doing about 40 percent of the total housing funding, in one way or another.It seems to me that, circumstances being what they are now, that we have to deal with it as a separate industry.

Our point of view is that thrift ought to be principally in housing, and that the other things they do ought to be compatible with housing. It ought not to be an industry which is really a bank, with some special privileges against ordinary banks. So, we think clearly that it ought to be a thrift industry and not an industry which has a special charter which gives it advantages over the regular banks.

Senator **Domenici**. So, you would say to us that we ought to leave this theoretical discussion about need to the theoreticians for awhile, acknowledge that it is part of the system, and get on wtih fixing it. Is that the answer?

Mr. **Seidman**. That is the answer and, further, the customer will decide it ultimately. They will not make it if the customer does not find the service.

Senator **Domenici**. Now, Mr. Seidman, there has been a lot of discussion about what is going on in the industry in transition. We have read that certain of those that are insolvent are now advertising higher interest rates to try to attract depositors, all of which might end up costing us more, rather than less. That is the arithmetic of this kind of proposition, because they are obligated to pay those high interest rates and whoever takes over has to fulfill this obligation.

We have heard testimony and experts say we are dragging many of these cases on too long, that we ought to close a number of them and get on with it. Could you address for us the issue of how urgent is it that we move quickly. If we do not, what are the principal things that are happening out there, in your opinion?

Mr. **Seidman**. I think it is urgent. First, we are losing money every day that we do not deal with these institutions. As I said, about the best we can estimate now is $200 million or $6 billion a year. It is clear to me that the cost will go up with higher interest rates. Therefore, it is urgent from that point of view. It is urgent because they are disrupting the overall financial system because of the higher rates they have to pay, and that spreads out through the whole industry. Therefore, it is urgent that we do it in that way and, it is urgent that we get those situations back into private hands in a way that they can become a real part of the private sector. Now they are a kind of a ward of the State, so I think for all of those reasons it is very important that we act swiftly, that you act swiftly.

Senator **Domenici**. Mr. Chairman, I see the red light is on. Senator Armstrong is next, but could I ask one question, because I have to leave and turn this over to you? Would you defer for 30 seconds? Is that all right with you, Mr. Chairman.

Chairman **Sasser**. If it is all right with Senator Armstrong, it is probably all right with me, Senator Domenici.

Senator **Armstrong**. Yes, Senator.

Senator **Domenici**. Mr. Seidman, could you outline quickly for us what you are recommending with reference to regulatory authority that is different from what we have got now. What are you going to do that gives us and the American people some assurance that there is going to be minimum risk out there, instead of maximum, even in changing economic times, and that a minimal amount of fraud is going to occur in the future?

Mr. **Seidman**. Really, we are recommending two basic changes with regard to the thrift industry. One, the insurer is going to be independent and is going to have the power to operate almost like a private corporation. That means it can decline to insure an institution if it does not think it is insurable, it can terminate insurance on short order if the institution is not operating in a safe and sound manner, it can order the institution to take action if its primary regulator does not do so, and it has the power to raise insurance premiums if the losses overall in the industry are exceeding premium income. In effect, the institutions are going to have to behave in an insurable manner or the insurance fund will terminate the insurance.

Second, we are recommending that the kinds of things that can be done in the insured institution be limited to the least risky types of operations. That the other things that the institution may want to do be done should be in a separate subsidiary, with separate capital, so that if those riskier enterprises fail, the insured institution will not be affected. That, of course, will take very good firewalls between the subsidiary and the main institution. Those are the two basic approaches.

Senator DOMENICI. On your first recommendation, are you saying that if the auditing group is not handling an institution right and you see that, you will step in and give them so much time to fix it up or say we are not going to insure it, because the rules are not adequate to protect it?

Mr. SEIDMAN. Absolutely, and the insurance fund will be able to do that. Regardless of what anyone else says, they will have the power to do that.

Senator DOMENICI. Thank you, Mr. Chairman.

Chairman SASSER. Senator Armstrong.

Senator ARMSTRONG. Mr. Seidman, I did not quite follow what we were just talking about. We were talking about risk-weighted capital, and maybe I did not understand the import of Senator Domenici's question. Could we just track back through that for a minute? Maybe I did not understand his question or perhaps I did not fully follow your answer.

Mr. SEIDMAN. As I understood the question, it was what kind of assurances are there that there will be powers and changes in the structure that will prevent this kind of thing from happening again.

Senator ARMSTRONG. Oh, and you were saying that the risk-weighted capital requirements——

Mr. SEIDMAN. I did not comment on the risk-weighted capital requirements, except to say that the insurer will have a number of powers to deal with insured institutions. These powers will include setting minimum capital, determining whether they are operating in an insurable manner, and the power to terminate insurance if they do not.

Senator ARMSTRONG. Well, are you distinguishing minimum capital from the risk-weighted minimum capital?

Mr. SEIDMAN. I am really only addressing minimum standards and saying that the insurer can set minimum standards for capital, whether it is risk-weighted or direct gearing ratio or whatever it may be.

Senator ARMSTRONG. Well, that leads me to what I was going to ask anyway, and that is why I was thrown off a little by what Senator Domenici suggested. I take it that there is still under development some final plan for what the gearing ratio is going to be? Have you announced or can you tell us what your schedule is for that?

Mr. SEIDMAN. We will be announcing our capital risk plan within I think the next 2 weeks. It will be very similar to that that has been announced by the Comptroller's office and the Federal Reserve.

Senator ARMSTRONG. And will that include the so-called gearing ratio?

Mr. SEIDMAN. It will. In our case, we have said that we want both risk-weighted capital and gearing for total percentage capital, and that we want the higher of those two standards.

Senator ARMSTRONG. Well, that leads me to another matter that is of great interest to me and I hope will emerge as a topic of interest to a lot of people as they think about it. I very strongly support the risk-weighted capital notion, but it has occurred to me to wonder why there has not been more focus on risk-weighted deposit insurance premiums. I know that has crossed your mind and I am sure you have thought about it. Is that something that the industry and the Congress should be thinking about?

Mr. SEIDMAN. That is provided for in the President's plan, the power for the insurer to set premiums, taking into account risk. I think it is an important thing and, if authorized, I am sure the agency will proceed to attempt to do that. It is not easy, if you take every institution and rate it every year, because estimating risk is difficult. I have to point out that the best capitalized, more profitable banks in the United States 6 or 7 years ago were in Texas. Now all of the major ones, except one or two, have had to be aided. So, it is a difficult thing to do. Nonetheless, I think the agency ought to undertake it, if authorized.

Senator ARMSTRONG. I agree with that. However, at the risk of suggesting something which is perhaps so obvious that it is just naive, one way that the deposit insurance fund could accomplish this without any complex transactions is simply relate the premium to the level of capital. In other words, your risk-weighted capital requirements are the minimums, but for those institutions which are significantly above the minimums it would be easy to give them a discount, or the converse of that would be to say for those that were at or near the minimums, they would pay a higher premium than those that were at a much higher level. I mean that would net out all the questions of trying to evaluate their loan portfolio and just bring it down to an existing risk-weighted analysis.

Mr. SEIDMAN. Well, that certainly is possible and that would be one way to set it. Capital is not the only estimate of risk, but it is one of them. Incidentally, my staff tells me, unfortunately—I had not realized this—that while the risk-based premiums were in the President's plan, they were taken out at the last minute. I am sad to hear that. I thought they were still in it.

Senator ARMSTRONG. Is that a power that would require a statutory change?

Mr. SEIDMAN. It would, yes, and we have asked Congress for it several times and will certainly support it.

Senator ARMSTRONG. I would think that would be something that the Congress would want to look at.

Could we now go to the question of the thrifts? I followed with interest your discussion with Senator Domenici on whether or not we need a separate industry, but begging that question for a moment, is there any reason in your view why we should not now let the banks acquire thrifts, whether healthy or not, for that matter, once the President's plan is in place or whatever Congress comes up with, thrifts to acquire banks and vice versa?

Mr. SEIDMAN. I see no reason why that should not be the case, and either one can acquire the other and operate them under the general rules for that type of institution.

Senator ARMSTRONG. One other question that occurs to me. You were quoted, I think, in an article that appeared in the paper yesterday as saying that the FDIC would soon promulgate—I believe that this was attributed to you, that you were going to promulgate rules on growth and provide a limitation on growth or the right to review growth. The article was not very satisfying as to your reasoning, but it alluded to the fact that you were concerned about brokered deposits. Is that in fact the reason that is under consideration?

Mr. SEIDMAN. It is under consideration because the record clearly shows that institutions that grow at exorbitant rates through using brokered deposits have been very costly to the insurance funds. That is clearly one of the key problems in the S&L industry, and what we are trying to do is to get at the problem before it happens, instead of afterwards. Supervisors have often been said to be those who arrive on the battlefield after the war and shoot the wounded. Our basic approach is to try to get there before and see if we can reduce losses. We are saying, in effect, that if growth is far above industry averages, that growth ought to be explained to the supervisor if they have plans for such growth.

Senator ARMSTRONG. Mr. Chairman, my time is expired, but with your indulgence, I would like to proceed for a moment or two.

Chairman SASSER. You go right ahead.

Senator ARMSTRONG. I rarely, and only with great trepidation, would dispute your conclusions, but I must say that I find what you have just said is very surprising. I certainly agree that there is a problem, and I think you correctly summarized the feeling of regulators to get ahead of that problem. But it is not plain to me at all that the problem is growth, nor even the source of deposits. It is what the institutions do with the money.

If an institution, for example, is using brokered deposits and growing 100 or 200 percent a year, as some institutions have—it is a rare thing, but some have—and investing the proceeds in T bonds, that does not sound risky to me. On the other hand, if they are getting so-called "core deposits," because they have a lavish lobby location or some other reason, and are investing the proceeds in some of the kinds of construction lending, junk bonds and other things that have gotten institutions in trouble, that does not sound safe to me if they are only growing 4 percent a year.

So, the thing that I found puzzling about the article and I find puzzling about your response this morning is the emphasis on growth, rather than what seems to me to be the real problem, which is the asset quality.

Mr. SEIDMAN. In fact, Senator, that is exactly what we are doing. We are not concerned with growth per se, except to find out what they are going to do with the money.

Senator ARMSTRONG. I see. In other words——

Mr. SEIDMAN. And that is why we are asking them.

Senator ARMSTRONG. In other words, if somebody says they are going to be triggered by this, that is only for review purposes——

Mr. SEIDMAN. That is exactly right.

Senator ARMSTRONG. But the real problem you are aiming at is what are they doing with the funds.

Mr. SEIDMAN. That is the purpose of the rule.

Senator ARMSTRONG. Mr. Chairman, I think most people in government get praised more than they deserve and I think Bill Seidman is a rare exception to that. I just think you are doing a great job and I compliment you for being a voice of reason and a thoughtful voice in a very chaotic turbulent time and we are all indebted to you.

Mr. SEIDMAN. Thank you.

Senator ARMSTRONG. Thank you, Mr. Chairman.

Chairman SASSER. Thank you, Senator Armstrong.

Mr. Seidman, many of the deals that were worked out by the FSLIC last year offer the new owners little or no incentive to turn the S&L's around, and I think you and I probably share concern about what happened last year. But these owners have no incentive, really, to turn the S&L's around, because they are guaranteed a return on their non-performing assets. It does not matter if the economy is going up or growing or stagnant or interest rates are up or down. These S&L's are going to stay in business with government financing and, as you indicated earlier, they are sort of wards of the government.

Do you see any incentives in this new plan that would encourage thrifts subsidized through a system arrangement to work hard to turn their finances around?

Mr. SEIDMAN. I have not examined those contracts, Mr. Chairman, so I do not know. I have been informed that some of the later contracts did try to build in some incentives for the operator to improve performance and to move things back into the private sector. I have not seen those, but in general income maintenance contracts, which we had some of in earlier days, simply do not provide incentives for the institution to really return to a private-sector type of operation.

Chairman SASSER. Well, do you not think it would be a good idea to come up with incentives to move these people down the line in the direction of getting back in the private sector?

Mr. SEIDMAN. That is certainly what we do when we take care of failed banks. We have not signed any of these kinds of contracts. On the other hand, we have had resources. The Bank Board did not have any resources, except to sign notes and contracts, so they did what they could with what they had. But I think there is no question that we would look long and hard before we would continue that kind of disposal of assets if we have resources to do something else.

Chairman SASSER. Well, one of the reasons I think the Bank Board did not have any resources is they were telling the Congress last year that things were OK. Now, in their defense, I think some of us knew that they were not OK, and if we had probed deeper and pushed a little harder, I think some of the problems would have surfaced, but we followed the course of least resistance and took those false assurances when we should have known better.

But as you probably know, it has been exceedingly difficult to get accurate information about FSLIC's budget. Just 3 weeks ago, FSLIC sent us back a response to a series of questions focused on translating all of the present value accounting into cash terms. In too many cases, their response to our questions about the cash end of it was that the cash equivalent of their net present value figure was either not available or was really not meaningful in any case.

Now, in your statement, I note that you think the appropriate basis on which to discuss the size of the S&L problem is also net present value and not cash. Now, here is the problem with that, as I see it. Under Gramm-Rudman, every cash dollar of net FSLIC spending is a dollar that we cannot spend on other programs. If we spend it on FSLIC, because of Gramm-Rudman-Hollings, we have got to take it out of the economic development program, we have got to take it out of housing, we have got to take it out of education.

So, I think cash basis information is meaningful. The Federal budget measure is Federal expenditures on a cash basis, and as you know, these targets we have got to hit are calculated on a cash basis. Now, I understand in a business, in an economic sense, it is appropriate to talk about the size of the problem in net present value terms. But the administration's plan is using Treasury funds and taxpayer dollars for any short-falls, and the taxpayers' ultimate costs, the budget cost, is going to be measured and paid for in cash.

So, why is it more appropriate to talk about the size of the problem in cash terms? We as budgeteers have got to talk about it in cash terms.

Mr. SEIDMAN. I think, Mr. Chairman, it is very appropriate to talk about it in both terms. I think the net present value gives you a base, if you could pay it all off today. However, since you know you are not going to do that, you have to look at the cash out-flows in order to estimate what it is going to cost you over the long term. It is the same thing as buying a house. If you buy it for $100,000 cash, it costs you $100,000; but if you get a 30-year mortgage and pay 10 percent, before you get done it is going to cost you almost $400 thousand. So, I think to make intelligent choices, you have to have both numbers.

Chairman SASSER. Senator Grassley.

Senator GRASSLEY. Thank you very much, Mr. Chairman.

I am sorry I did not have a chance, Mr. Seidman, to hear your testimony, but I have read lots of things that you said on this matter over the last several months, and so when I talk to you about the problems of our financial institutions, I hope you know I have a little bit of background on what you have said, even though I did not hear your testimony.

My first point is not so much a question as a statement of support. I am especially pleased with the renewed endeavor to tackle fraud at financial institutions. This part of this plan is critical, not only to collect monies that were lost due to misconduct, but also to diminish the occurrence of fraud in the future, and then I think it has got this corollary benefit, because further, if the public is assured that government officials are serious about stopping mismanagement and abuse at financial institutions, and that it will not be business as usual at some of these institutions, then the public may be less resistant to a taxpayer bailout of FSLIC, and that is a major problem. I mean the public just thinks, that is the taxpayer, why should they have to pay for this, and it is important that we have people in your position—I said this to the person who was here yesterday, that we have to have a lot of help—it was Secretary Brady yesterday—we have to have a lot of help from people in public positions to build up the support for this, and of course guarantee that it is not going to happen again, and vigorous regulation and vigorous examination is an important part of that.

As an aside to this point, I hope that you and your people do not neglect the possibility of fraud at institutions not yet designated as insolvent. I assume you are considering that.

Mr. SEIDMAN. That is a part of our regular supervision. When I first got to the agency, we put out what we called our red flags, which were all kinds of red flags that there might be fraud in the institution. When our examiners find something that looks like then they bring in our special fraud squad which is trained to follow up on those things and search out fraud. We will never get it all, but we are emphasizing that.

Senator GRASSLEY. Without going into too much detail, I would appreciate some clarification on how the activities at the FDIC will coordinate with those of the Justice Department, in their attempts to address fraud.

Mr. SEIDMAN. There is an interagency task force to address fraud, and we work very closely with the Justice Department. In some cases, they have not had the resources to pursue all the things that we would like to have seen pursued. The President's plan provides some extra funding for them in that regard, so we will be working jointly with them to pursue fraud wherever we find it.

Senator GRASSLEY. Let me ask you before I go on, that arrangement has been operational, so you have got some confidence that it is working and you are not in the turf battles and all of those things that sometimes interfere with getting the job done?

Mr. SEIDMAN. I think it has been working well. It has been in place for a couple of years and I think it is working well.

Senator GRASSLEY. Now, I have been briefed that throughout your statement you have made these points about deposits being safe and that the impact on depositors and customers will be minimal. I am concerned about this, for two reasons, both which I shared with Secretary Brady yesterday.

First, public fear and insecurity is causing, what I want to emphasize, a slow run on savings institutions; and, second, taxpayers oppose a public bailout, there is the perception that they, the taxpayers, are responsible for the problems, so the taxpayers should be responsible for fixing it.

I hoped that you will assist the Congress in building public support for the necessary solution. The Members of Congress will be expected to take a leap of faith and vote for those plans, even though it is unpopular with many constituents, and I hope that we can expect your assistance in building this public support beyond just the mere statements of the maintenance of safety for deposits. I think many of the points raised in your statement particularly address the impact on customers is helpful.

Now, moving on to another point, the FDIC has sometimes provided coverage for deposits in excess of $100,000. I understand that this action was taken to forestall prospective runs on banks just prior to closure. However, it is also my understanding that the FDIC does not provide coverage for deposits in excess of $100,000, when smaller institutions such as we might have and do have in my State, require action by the FDIC.

Now, I wholeheartedly oppose the policy of "too big to fail," and request that the Budget Committee examine the extent to which this policy exposes the Treasury. I believe that we should also examine the extent to which it poses an unjust burden on smaller banks and their customers, the expense of bailing out several large banks has drawn down the insurance fund, small banks and their customers must now pay higher premiums to restore the appropriate reserve balance to the FDIC.

Have you examined the possibility of assessing deposits in excess of $100,000 for insurance funds or restrict insurance coverage above the $100,000 threshold?

Mr. SEIDMAN. The premiums are on total deposits, not on uninsured deposits, so we already charge institutions on total deposits.

In our study, we extensively looked at whether we could change the $100,000 limit or whether we could, if you will, get out of the "too-big-to-fail" responsibility. We have found in our experience that when these large institutions get in trouble, the big losers, if we do not protect the whole institution, are small banks who are generally the depositors.

When First Republic failed or had its run, most of the money that was running out was going to small banks and they were the ones who lose. So small bankers are often a little bit schizophrenic. They want us to save the big bank because it is their money that is going to be tied if we do not. On the other hand, they think it is unfair that deposits are covered in big banks and not in the same way in small banks.

In fact, we cover all deposits in 99 percent of all the cases that we handle, because we generally transfer the whole failed institution to some other bank or buyer. In that way all depositors are protected. There are some small institutions where we cannot find a buyer. In those cases there may be a small percentage of money over the $100,000 which will not receive the full amount. Out of the total work that we do, that is less than 1 percent of the deposits that we handle.

Senator GRASSLEY. Mr. Chairman, let me follow up just shortly. Maybe what I ought to be asking you, then, is more a question of philosophy than a question of just what the situation is.

Should not people that are getting protection above the $100,000 then pay something for that additional protection?

Mr. SEIDMAN. First, the bank is paying on all deposits. Senator Grassley. I know it.

Mr. SEIDMAN. Second, yes, you could say that for larger amounts you could raise the premiums higher. The big banks will argue that what they would like to do is pay premiums on their insured deposits, because that is much less. So you could, if you thought it appropriate, put a user tax on accounts over $100,000 and have them pay higher amounts. That would undoubtedly move funds out of the banking system, into alternative places.

Senator GRASSLEY. All of a sudden somebody is getting a benefit that was not anticipated. I am not arguing with your reason for doing it, but it just seems to me like it has an unfair element in it and that somebody ought to be paying for it, rather than the run-of-the-mill person that is paying today.

Senator ARMSTRONG. Mr. Chairman, could we go back to the point that Senator Grassley was raising about what happens when the insurance is withdrawn.

There would not be, there has not been in the past and I assume there would never be in the future, an occasion where the insurance was withdrawn but the bank continued to operate?

Mr. SEIDMAN. No, by withdrawing the insurance the bank basically will not be able to gather any more deposits. People will have 6 months to take their money out of the bank. The bank will be insured for 6 months after the insurance is withdrawn, but not after that, so the bank will simply——

Senator ARMSTRONG. Even more than that, it is in essence unthinkable that the bank would continue to operate, because the instant you withdraw the insurance coverage, the OCR or the State banking authorities or somebody closes or merges the bank——

Mr. SEIDMAN. It will be insolvent.

Senator ARMSTRONG. So there is not any interim period where they would be operating without insurance?

Mr. SEIDMAN. I cannot think of any time that would happen. That is correct.

Chairman SASSER. Do you have any further questions, Senator Armstrong?

Senator ARMSTRONG. No, Mr. Chairman. That was just for the benefit of staff. We were just kind of educating our understanding of how this thing works.

Chairman SASSER. Mr. Seidman, your statement indicates that you think the FDIC and FSLIC Insurance Fund should be separately budgeted and should not be a part of the general budget. You assign as a reason for that that these agencies receive no taxpayer dollars but, of course, as we all know, at least one of these agencies now is in need of a major taxpayer bailout.

Now, I just released yesterday a preliminary analysis of the S&L bailout plan that we put together here on the Senate Budget Committee, using the administration's own figures that indicate that almost $80 billion will be needed in taxpayer dollars over the next 10 years to rectify this problem.

In my mind, FSLIC and FDIC are both Federal agencies. The only budget issue to me is how do we inject a degree of budgetary discipline to prevent a repeat of last year's spending spree on the part of FSLIC, while preserving the necessary independence of the insurance fund? That is a tough proposition.

Before I ask you to answer, let me just say this: I think that the President's bailout package does make an attempt in this direction, which I think is not too far off the mark. Included is a proposal to limit FSLIC and FDIC's contingent liabilities to 50 percent of the fund's net worth. What do you have to say about this?

Mr. SEIDMAN. We agree that they ought to be limited. We think the limitation ought to be a simple one that we can use. One that ensures that the taxpayers will not have to pay anything, because the liabilities incurred cannot exceed the assets in the fund. So, we agree, but we think there ought to be a simple limitation that says that the institution is not authorized to issue notes or other similar obligations which will put the fund in a deficit position.

Chairman SASSER. Well, now that is good, but I note that you also say in your testimony that you would prefer to rely on a GAO audit to determine the limits of FDIC's resources which can be committed to the so-called credit card arrangements. But as you said about the examiners or the supervisors a moment ago, an audit is really in retrospect. In other words, by the time the GAO completes an audit, it could be a year or a year and a half after the fact, and it is after the battle, to use your analogy a moment ago. We know from experience that FSLIC in 1 month alone spent about $38 billion, if memory serves me correctly, and God knows what could happen if we give them a year and a half to operate. Is there not some way that the tracking of expenditures could be more current, so that we in the Congress would know how close to the Gramm-Rudman limits the budget deficit is going to be, for example?

Mr. SEIDMAN. I think there is, Mr. Chairman. First, with respect to FSLIC, they were insolvent at the beginning of the year, so under what we propose you would not have been able to issue $1 of obligations. Therefore, that kind of thing could not have been repeated.

We would have no objection to using the GAO audit as a starting point and using the agency's current financial statement, if they show losses, to reduce the amount. The objective of our position is to insure that the agency cannot issue obligations which will be in excess of the resources which they have at the moment to pay for them.

Chairman SASSER. Mr. Seidman, a moment ago, in response to one of my questions about what would happen if deposit based growth was not as large as the bailout plan anticipated, you indicated that any short-falls in income from the failure of the deposit base to grow would be relatively small income losses.

We were just doing a little calculating and we became victims of sort of the Washington syndrome here. That relatively small loss could be from $2 to $400 million a year. Now, that would buy a lot of economic development and do a lot in the field of education, homeless assistance, et cetera.

People ask me, "Senator, where did the $100 billion go?" Where did the $100 billion go?

Mr. SEIDMAN. The $100 billion went to fraud, insider abuse—people stealing money. It went to the last seller of raw land at huge prices, above real values, so that someone borrowed money and paid somebody else five times what the land was worth. He walked off with the money, the fellow who borrowed it went broke and the money is now in the hands of the seller. It went to imprudent loans for windmill farms and other kinds of very high-risk economic activities which, because they were high risk, went broke and there is no value there. That is why there is no real way to recover these funds in large measure. Because they have been lost through either fraud, investment in imprudent activities, or they have been lost by payments for land and other things that were far above a sustainable price. Chairman Sasser. Do you know of any precedent for this type of loss experience in the history of American financial institutions?

Mr. SEIDMAN. There certainly has been nothing of this magnitude. There have been things like this before, but there has been nothing of this magnitude. When these institutions were deregulated, it was not recognized that deregulation requires more, not less, supervision.

Chairman SASSER. Mr. Seidman, we thank you very much for your appearance here this morning. It has been very helpful. I am advised by staff, before closing these hearings, to reassure depositors that the full faith and credit of the Federal Government stands behind the Nation's banking and S&L industry, so nobody rush out and take your money out of the neighborhood S&L.

Mr. SEIDMAN. Thank you very much, Mr. Chairman.

Chairman SASSER. Thank you very much, Mr. Seidman.

The committee is now adjourned.

[Whereupon, at 11:22 a.m., the committee was adjourned.]

PRESIDENT BUSH'S PROPOSALS FOR HEALTH AND HUMAN SERVICES

WEDNESDAY, MARCH 8, 1989

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to notice, at 10:03 a.m., in room SD-608, Dirksen Senate Office Building, Hon. Jim Sasser (chairman of the committee) presiding.

Present: Senators Sasser, Exon, Lautenberg, Simon, Fowler, Conrad, Robb, Domenici, Kasten, Nickles, and Bond.

Staff present: John L. Hilley, staff director; and Kathy Deignan, assistant director for human resources.

For the minority: G. William Hoagland, staff director; and Jeffrey Sanders, senior analyst for social security, medicare and health.

OPENING STATEMENT OF CHAIRMAN SASSER

Chairman SASSER. The committee will come to order.

Today, the Budget Committee is pleased to welcome Dr. Louis W. Sullivan, the Secretary of the Department of Health and Human Services, to testify on behalf of President Bush's 1990 budget.

Dr. Sullivan, it is a personal pleasure for me to welcome you here this morning, and just to say to you, sir, that your job is among the most important in the Federal Government, in my opinion. You have responsibilities for programs that affect the lives of virtually every American citizen, whether it is providing medicare to the elderly, health care to low-income women and children, finding cures for AIDS and cancer, or maintaining a strong social security system which provides basic income security for millions of elderly Americans.

I would say to you, Dr. Sullivan, that so far it has been difficult for some of us really to get to the bottom of what many of the Bush budget priorities are for your department. The administration's budget document does not, for example, tell us very much about priorities for maternal and child health, community health centers, or the community services block grant. So I think it will be of immeasurable help to us, Dr. Sullivan, to have your views on how the department may want these programs funded.

In other areas, the administration has proposed substantial funding increases for some very, very worthwhile programs. One, Head Start. I am enthusiastic that the administration has seen fit to enlarge funding for this program, and I would like to see the Head

Start Program in the years ahead enlarged even further. I am also pleased to see that there is additional funding for AIDS research in the administration's budget, and I applaud these initiatives.

I might say, parenthetically, that I sure hope we can find a way to pay for them.

I might say also there are some short-sighted portions of the department's budget in my view.

Perhaps the most glaring is the $5.2 billion reduction proposed for medicare, a reduction that would take some $57 billion out of medicare over the next 5 years.

The administration budget suggests that a $5.2 billion reduction would have no impact on services for medicare beneficiaries. I seriously doubt that proposition.

Cuts of the magnitude that are being proposed I think are going to result in hospital closures. For example, in my State of Tennessee last year, we had four hospitals which closed, and we are told that with these medicare cuts, two-thirds of all the hospitals will lose money caring for medicare patients. This comes on top of many hospitals telling us, informally, that they are losing money on medicaid patients.

This will, I think, precipitate a real crunch for rural hospitals around the country and for the major teaching hospitals in many of our urban areas.

The budget proposal also calls for $16 billion more in medicare beneficiary premiums in the next 5 years. Now, these premiums that are paid by the beneficiaries come on top of new catastrophic premiums passed last year.

So, unhappily, the medicare beneficiaries of this country seem to be told that they are going to have to pay more and get less from medicare in the years ahead.

Well, I hope that is a situation that we can avoid, Dr. Sullivan, and I hope that you will review this budget again and use your good offices and powers of persuasion and influence with Mr. Richard Darman, the Director of the Office of Management and Budget, to convince him not to be so hard-hearted on some of these programs. Mr. Darman on occasion does evidence a soft heart, and maybe you can soften it up even more and see if we cannot enlarge on these programs that impact so beneficially on the American people.

I will turn now to Senator Domenici for any comments or statements he may wish to make this morning.

OPENING STATEMENT OF SENATOR DOMENICI

Senator DOMENICI. Thank you very much, Mr. Chairman.

Welcome, Secretary Sullivan. It is a pleasure to have you here. I have not had the privilege yet of talking with you personally with reference to a number of issues that I hope are of common interest. But let me say I am also aware that you have not been in the position of Secretary for very long. Thus, you are preparing and getting ready, and I, for one, understand that.

You probably already know that the job you have is a tough one. HHS is the largest Federal agency in dollars. You oversee the fourth largest budget in the world, exceeded only by national budgets of the United States, the Soviet Union, and Japan. That is a rather formidable thought. There is social security, critical welfare programs, Head Start—which has been mentioned by our chairman—and serious issues like biomedical research. I want to take one of those in a minute and tell you about my interest, but one of your programs, social security, is so big now that it is not only discussed in terms of the social insurance aspects, but it is talked about in terms of its effect on the overall American economy.

Your budget is not only big, but from my reading of the President's recommendations, you are in a growth budget as compared to others. The President is distributing about $14 billion in outlay increases throughout this budget. Strangely enough, you get a $25 billion outlay increase. That means he is assuming that in total other budgets will go down. In total, other programs will go down and your programs in total will go up.

Let me return to medicare and medicaid, two of the fastest growing federal programs. I hope that if you are not aware of the trends and the problems, you will devote a great deal of your attention during the ensuing years to health care—not only to medicare, medicaid, but the overall system as well.

The United States is very proud of its health delivery system, but we have not been able to stabilize spending for it as other countries have. Health care spending goes up much higher than inflation every year. It is now about 11 percent of our gross national product. There is no industrial nation that comes close to spending as much on health care. These are real serious issues.

It seems to me that we have tended to tinker around the edges of the health care system. As you look at this system in the ensuing years, my hope is that someone of your capabilities will lend some real study to these programs, not by way of hurting anyone or taking away benefits, but trying to make a little better sense out of them. Perhaps we can get a better health delivery system over the long run without it growing at 13 and 14 percent a year when inflation is 4 percent. I think that is the challenge of our day.

I will put it in perspective this way. Shortly after the turn of the century, if we continue as we are, believe it or not, the Medicare payments per year to those entitled to benefits will exceed the annual payments to social security recipients. A rather dramatic thought.

We do not have the money to pay for that, but that is where it will go. We will be paying more in medicare than we will in the actual benefit checks to the social security recipients. Those facts deserve a lot of attention.

My last thought is you were custodian of America's real scientific research in the National Institutes of Health, the National Institutes of Mental Health, and their related departments. It is imperative that we keep the highest scientific standard there. We are aware that pay is an issue because we are losing a lot of scientists. We want to make sure that where we have competence and professionalism that you do everything you can to keep it.

In that regard, I am very proud of the National Institutes of Mental Health and ADAMHA, and I urge that as you move through the placement of professionals that you look at NIMH very carefully. They just put their team together within the last 6 or 8 months under Dr. Judd. And I think it is imperative that since they are moving ahead dramatically that we not arbitrarily destroy that professionalism.

Thank you very much, Mr. Chairman.

Chairman **Sasser**. Thank you very much, Senator Domenici.

We will turn now to Dr. Sullivan for his statement.

STATEMENT OF HON. LOUIS W. SULLIVAN, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary **Sullivan**. Thank you very much, Mr. Chairman, Mr. Domenici, Mr. Exon, Mr. Conrad, Senator Robb.

I am pleased to be here today in my first senatorial appearance since my confirmation by the Senate. I wish to discuss with you President Bush's budget proposals for health and human services. I am pleased to enjoy the trust of our new President, and as Secretary for Health and Human Services, I shall carry out the task that he has given me in such a way that the hopes and aspirations that we mutually hold for this department and for the American people are fulfilled.

Today, I am privileged to have the opportunity to discuss with this distinguished committee the broad contours of those hopes and aspirations. They center on the President's commitment—a commitment I fully share—to the ideal of a "kinder, gentler" America. No department will be more directly affected by that commitment than Health and Human Services, which touches the lives of all Americans wherever they are most vulnerable, from the beginning of life, through health and sickness, from the foods we eat to the medicines we take, and to the care of our elderly and disabled among us.

Taking that commitment as my guide, I intend to see to it that our policies carry a firm, but gentle touch; that our employees take pride in the services they render to our fellow citizens; and that by doing so the federal government itself comes to have a more human face. Bringing a new spirit of kindness and compassion to a vast Federal department of with over 120,000 employees may seem excessively idealistic, but it is an ideal we can attain. Nothing less shall be my goal as Secretary.

During my medical career, I have seen remarkable progress in our Nation's system of health care, with programs like medicare and medicaid making health care available to the elderly and to the poor. And I have seen improvements in the lives of our children and less privileged through the programs of this department.

Nonetheless, much remains to be done. But it must be done with an eye towards reducing the Federal budget deficit—a concern, I know that is shared by this committee.

Let me indicate how we might begin to make further progress towards improving the health and well-being of our citizens, bearing these budget constraints mentioned in mind.

First, we are committed to assuring the solvency of programs like social security and medicare. We must find ways to contain escalating costs, as already mentioned, without sacrificing our commitment to quality health care for all. We must emphasize health promotion and preventive medicine strategies, because promoting health is ultimately more humane and more economical than merely treating illness.

In only 6 short years since the Bipartisan Commission put the social security trust funds back on the road to solvency, we can report that in 1990 trust fund income will exceed outgo by nearly $69 billion. The combined reserves of the Old Age and Survivors Trust Fund and the Disability Trust Fund will be approximately $229 billion by the end of 1990. By 1992, the trust funds will have a full year of reserves. The reserves are necessary, and will be used, to fund the benefits of the "Baby Boom" generation as they begin retiring after the year 2000.

President Bush proposes to increase medicare spending by about 10 percent, or a total of $8 billion, in 1990 compared with 1989. Thus, we are restraining the increase rather than having an absolute cut in dollars, while at the same time we must restrain excessive growth in our health care system.

Second, we must sustain and improve programs like Head Start and Aid to Families with Dependent Children—programs that help the poor learn and work their way out of poverty. Thus, implementation of last year's welfare reform legislation in the Family Support Act will be one of my highest and earliest priorities.

The Act's most fundamental change was the creation of a new program of work and training activities, the Job Opportunities and Basic Skills Program, or JOBS, which all States must have in effect by October of 1990. States can elect to replace existing work programs with JOBS as early as July of this year. I intend to assure speedy implementation of this Act, by the issuance of program regulations early this spring. We must do all that we can to encourage welfare recipients to become productive members of the country's workforce.

Welfare reform also made improvements to child support enforcement laws, and I want to report to this committee today that child support collections continue to rise. We project that increases in 1990 will exceed 1989 estimates by 17 percent, or a total of $931 million. The strong congressional commitment to enforcement activities has helped bring this important parental financial responsibility issue to the forefront in State capitals across the country.

Preschool children from low-income families must be encouraged and given the opportunity to develop all of their talents. Head Start has been doing this for more than 20 years, and President Bush's priorities include a $1.5 billion request for this program, a 20 percent expansion. With this increase, up to 95,000 additional children, or nearly 550,000 in total. Can be enrolled in Head Start centers across the country, developing skills and enriching their minds and bodies.

Third, we must seek ways to strengthen family life and reinforce our society's sense of community, our shared sense of responsibility and commitment to one another. As President Bush has noted, "family . . . is a powerful word, full of emotional resonance," and those of us who have been blessed with strong families must work with those who have not such blessings.

Attention to family means that the health of our children must be our particular concern, for nothing less than our Nation's future is at stake. Today, that future is threatened by the epidemic of drug abuse among our young people. I am deeply committed to the battle against this scourge and will work long and hard with this committee, with the President, and with the President's drug adviser in pursuit of victory.

Young people must be educated to recognize and acknowledge the destructive impact of illegal drug use. President Bush has requested $35 million to initiate a new program to stimulate community partnerships—parents, schools, businesses, and community leaders—in order to develop innovative drug abuse prevention strategies.

We must also do more to help drug abusers reclaim healthy lives. The budget priorities of President Bush include $30 million for a new treatment initiative to aid communities with severe drug problems to expand treatment services.

We must also remove barriers to adoption, to help ensure that all children have an opportunity to grow up in a loving family and in a safe and nurturing home environment. The budget priorities of President Bush include fully funding adoption assistance payments to families adopting special needs children, complemented by a Federal income tax deduction for one-time costs for adoption.

Caring for the needs of the homeless exemplifies our commitment one to another. By fully funding the McKinney Act, this department will assist communities in bringing to the homeless critical primary health care services, mental health care, and a wide assortment of social services. A total of $189 million is directed to these specialized McKinney Act programs.

Fourth, we must sustain our biomedical research efforts in the quest for a cure for AIDS. As the President has said, "We must commit the resources and the will to find a cure. American science must know that we have the resolve to beat this disease." At the same time, however, we must not slight our efforts to find a cure for cancer, heart disease, diabetes, arthritis, and other disorders afflicting our citizens.

The Public Health Service will be spending $1.6 billion in 1990, which represents a 24 percent increase in the budget, on a wide array of AIDS research, prevention, and education activities. This unprecedented and enormous Federal fight against AIDS was advanced so rapidly only because of the knowledge gained through biomedical research over the last half-century. The National Institutes of Health, the embodiment of biomedical research in this country and recognized worldwide for its excellence, will have $6.8 billion available in 1990 for research on a variety of disorders, in addition to the $753 million of that amount which has been targeted for AIDS. Within the NIH increase, the President proposes a 6.6 percent increase for non-AIDS basic research and $100 million for the human genome mapping project.

Finally, in an era of limited resources, we must focus those resources on the poor, the disadvantaged, and the neglected in our society. We must focus first on the populations most at risk: mothers and children. Programs like medicaid must be carefully administered so that rural and inner city health care needs are met and the Nation's poor are accorded decent care with dignity. We will soon send to the Congress legislation to enhance medicaid services for children, including expansion of immunization services.

I would now like to return for a moment to the question of medicare spending. Within the department, the rising costs of medicare continue to be the primary force driving excessive budget growth. If no spending restraints were imposed, medicare benefit outlays would grow at a rate of over 14 percent in 1990, to a total of approximately $110 billion. However, simply extending three provisions—the 85 percent capital payment, the 25 percent part B premium floor, and extending clinical labs limits—would retain the policies currently in effect in this fiscal year. Allowing these provisions to expire would increase medicare spending by about $2 billion in 1990. Even with other proposals totaling about $3 billion in outlay reductions, the medicare program will still grow by 10 percent, or $10 billion in 1990, and growth in medicare part B costs will still be more than 12 percent.

The 1990 medicare budget is based on a policy of responsible deficit reduction with savings proposals aimed at reducing unnecessary and unwarranted spending, while at the same time improving equity in payment levels for services. Growth in medicare expenditures for inpatient hospital services has moderated under the Prospective Payment System, or PPS. However, there remain subsidies in the hospital system which are clearly excessive, particularly in the area of reimbursement for capital expenditures. These excessive payments must be addressed, and we believe that this is the appropriate time to correct these problems in medicare part A. President Bush's budget contains proposals to reduce the growth in part A by almost $2.4 billion in 1990.

The budget also proposes a series of steps aimed at slowing the continuing high rate of increase in the medicare part B program while also bringing about improved equity in payment levels for services. Part B costs increased at a rate of 17 percent per year from 1979 to 1987 and 12 percent in 1988. Unlike part A, where the government has been able to address most costs through a single overall approach—the PPS—medicare Part B is a very complex program for which no overall approach has yet been identified for controlling cost increases. The steps proposed in this budget are not expected to be the whole solution to the problem but are measures clearly called for based upon our current knowledge. Increased attention should lead to more comprehensive and long-range solutions to the basic problem of large and continuing cost increases in part B.

For physicians' services, a graduated approach is taken in the budget to bring about more equitable payment levels. For primary care services, which are underpaid relative to other services, the budget proposes to increase prevailing charges by the full Medicare Economic Index in each of the next 3 years. For most non-primary care physicians' services, the budget does propose to freeze prevailing charges for 1 year. For certain specialties and procedures that the Physician Payment Review Commission has identified as overpriced, the budget proposes to reduce payment levels in a graduated fashion, ranging from a 12 percent reduction for a number of selected procedures which have been identified, to an 8 percent reduction for radiology, anesthesiology and surgical services.

Mr. Chairman, we wish to make two things clear: First, we are not adamantly insisting that the proposals we suggest here are the only way to restrain medicare growth. We believe that they represent a fair and equitable approach, but the Administration is willing to discuss other approaches that the Congress or others may suggest. But, second, we must restrain medicare growth in some manner. We cannot allow medicare to continue to grow at a 14 percent annual growth rate, as noted by Mr. Domenici. Mr. Chairman, a 14 percent annual growth rate would result in medicare outlays in 1995, only 5 years away, of over $200 billion, virtually double what we are spending now. This level of growth in Medicare will make any new initiatives very difficult, if not impossible, to achieve.

Finally, I wish to highlight one of the priority initiatives of the President's program. The medicaid budget includes a series of program expansions aimed at improving the health of poor, pregnant women and young children. We propose to further expand medicaid coverage for infants and pregnant women whose income does not exceed 130 percent of the poverty level; require immunizations for all food stamp-eligible children under age 6, and provide funds to implement demonstration projects to decrease infant mortality and morbidity. We propose paying for this by phasing down special matching rates for certain administrative costs which have outlived their original purposes.

In summary, I would like to reiterate what the President and other administration officers have already stated. We are prepared to work together with the Congress in a bipartisan spirit and to put forth whatever level of effort it takes to reach a constructive budget agreement.

In that spirit, I would be pleased to try to respond to your questions, and, again, I appreciate the opportunity of appearing before you today.

Chairman SASSER. Thank you, Dr. Sullivan. I am going to curtail my questions here so that we can get to our colleagues' questions quicker. There is one question, however, that I do want to propound to you today.

We have all, I am sure, on this committee heard from hospitals in our respective States. They are telling us that these very large medicare cuts that are coming are just more than they can bear. They are telling us that they have been losing money on medicaid, and that they will start losing substantial sums on medicare, and that they continue to treat patients gratis, which many of them say they do, that they simply cannot survive. The American Hospital Association reports that 81 hospitals closed last year.

My question to you, doctor, is: From your experience in Georgia as a physician, as well as your experience here in the department, how severe do you judge the funding pressure to be on hospitals? And how are they responding to these funding pressures, in your judgment?

Secretary SULLIVAN. Thank you, Mr. Chairman.

I have several comments concerning this issue. First, the overall margin for teaching hospitals, remains at 5.3 percent. Within that group of hospitals obviously some are not as well off as others; beyond that, there is without a doubt excess capacity in the system which we cannot afford to pay for. Large urban hospitals have an occupancy rate of approximately 60 percent which leaves a number of excess beds that are not needed. In some rural hospitals, the occupancy rate averages 40 percent.

So we feel that rather than support excess beds, we need to have the flexibility, to utilize those funds in other areas where they are needed. We know that the hospitals have been undergoing some changes and restructuring in recent years, but more of that is required if we are to utilize the limited resources that we have in the most effective way.

Chairman SASSER. So if I understand what you are saying, Mr. Secretary, it would not be unanticipated that there would be additional hospital closures, and that would not be from the administration's viewpoint an entirely undesirable occurrence since we do have, according to your testimony, substantial over-capacity in the hospital system at the present time?

Secretary SULLIVAN. Obviously, it is hard to speak specifically on each hospital. We are concerned and are working to try to ensure, as best as we can, that access to facilities is available. However, in large metropolitan areas, there are sometimes 2,000, 3,000, even 5,000 excess beds. In those instances where there are other facilities, the closure of one does not represent a disaster for the community. We certainly do need to rid ourselves of excess capacity so that those funds can be freed up for use in other areas.

Chairman SASSER. Senator Domenici.

Senator DOMENICI. Thank you very much. I, too, will try to be quick, and I will submit a number of questions for the record.

Let me just make an observation with you. On page 6 of your statement, you said, "American science must know that we have the resolve to beat this disease [AIDS]," and then you state, "At the same time, however, we must not slight our efforts to conquer cancer, heart disease, diabetes, arthritis, and other disorders afflicting our citizens."

I would suggest that, if you are going to list significant health problems to the American society that you ought to include serious mental disease in that statement. I am firmly convinced that the facts are absolutely on the side that this is one of the most debilitating and broad-based diseases in the country. I would urge that you look at it in that context.

You might also note in the past 5 years its funding has been consistent and upward, and, as a result, great scientists are entering that field. It is unequivocal that in the last 6 years, we have made more breakthroughs in what goes on in the human brain than all of previous history. I urge that you give every consideration to that.

My second point is with reference to the human genome. This is a very exciting initiative, and I compliment you and the President for deciding to significantly increase funding. Indeed, the mapping of the human genome may present to scientists here and worldwide an opportunity to cure many, many of human beings' current ills. It is a preventive medicine approach of the highest order of priority.

I would say to you, however, there are two very different approaches. One is in NIH and, believe it or not, one is over in the Department of Energy, which got involved in the engineering of the genome. I would hope that as you look at this, you would not consider these approaches competitive, but, rather, supplementary and attempt to utilize the resources of both.

Secretary **Sullivan**. Thank you, Mr. Domenici.

Let me assure you that we are fully committed to the programs of ADAMHA and the very fine team there. We will not slight attention to mental illness. I agree fully with your comments.

The genome project, of course, is a very exciting one that is full of promise. That program is being coordinated by Dr. James Watson, who is head of the research program at Cold Spring Harbor, one of our leading private research institutes. Dr. Watson received with Dr. James Crick a Nobel Prize for their work. They were able to decipher the structure of the genetic code, DNA. Much of this new biology enables us to insert genes which produce human insulin into bacteria. We are able to increase the availability of human insulin at a much cheaper cost. Our increased understanding of the regulatory processes involved in human development was a result of the pioneering research of Dr. Watson.

We are very pleased that he is heading up and coordinating this effort under the Office of the Director at NIH. We fully agree with your comments about this project; it has tremendous potential for helping us solve many of the problems that still confront us.

Senator **Domenici**. Thank you, Mr. Chairman.

Chairman **Sasser**. Thank you, Senator Domenici.

Senator Exon.

Senator **Exon**. Mr. Chairman, thank you very much.

Welcome to you, Mr. Secretary. I knew and served as Governor with your predecessor, and I worked very closely with Secretary Bowen and we will be working very closely with you on a whole host of most difficult problems that you are going to be faced with in your important new position. I am glad you are there. The President has certainly made an excellent choice.

Secretary **Sullivan**. Thank you.

Senator **Exon**. Let me go back to some of your statements about the road to solvency, why in this administration reducing the Federal budget deficit is a must and so forth and so on. You have attempted to address that. I guess that I am not sure that those have been necessarily addressed along the lines of the gentler, kinder Nation, as expressed by the chairman of the committee in his opening remarks and questions to you.

Let me be specific, if I can, to try and put this in perspective. You talked a great deal this morning about trust funds, money that is there. You once again attempted to lay to rest any concern about social security because we have a huge, big trust fund built up there. I think it is not wise for us to emphasize that because, in my view, the social security money has all been spent. What we essentially have today is a great big cash register that everybody says: Look, it is bulging with money. The social security trust fund is in excellent shape. We have got $68 billion in there now, and it is going over $2 trillion by the year 2008, whenever it is, to take care of the baby boom.

The fact of the matter is we have got that big cash register there right now that says there is $68 billion in there, but when we open the drawer, there is so much IOU's. Really what we are doing is fooling ourselves with what I can best call energetic and oversimplistic bookkeeping that would not stand up very well when scrutiny would be forced on it by a CPA.

Another example of that is that the President in his State of the Union address said to us that we are going to have $80 billion in new revenue to spend. Did he not say that?

Well, is it not true that of that $80 billion that we have to spend, according to the President, about $24 billion of that is social security trust fund. And we have heard the President and members of the Senate say that we are not going to balance the budget on the back of the social security recipients.

Is it not fair to say, then, that rather than $80 billion to spend, we will have to subtract off the $24 billion of that $80 billion that comes from social security taxes? Therefore, we only have $56 billion to spend.

Secretary SULLIVAN. Well, of course, Senator, it depends upon how you look at it. I think the President was pointing out that we are, first of all, satisfying the obligations that we have to our citizens by making those revenues available. While they are a part of the overall $80 billion, we are ensuring that future commitments will be honored. I think you would agree, we certainly want to do that.

Senator EXON. Well, I would agree with that, but I am trying to point up the inconsistency of the bookkeeping in the plans and the programs as we are advancing in this area. I think we are going to run up against a buzz saw sooner or later on that kind of bookkeeping in trying to get down to unrealistic, attainable goals I suggest that have been set out.

Let me go to another problem we have here. In our attempt to be realistic on the budget and reduce the budget deficit, as we are all for, of course, are we not running the risk—with the cuts that have been made and proposed in various phases of medicare that you outlined very straightforwardly here this morning, are we not simply transferring a large percentage of the health care costs that we have experienced in the past? We are not going to pay for them. The senior citizens have to pay for them. And is that not more or less a direct reduction in the income to a substantial number of those presently receiving medicare?

Secretary SULLIVAN. Well, Senator Exon, the proposals that we outlined are designed to actually reduce the payments to third-party providers. We certainly do not intend for costs to be shifted to the patient. I believe we have about 12 medical procedures that everyone agrees with PPRC that are overpriced procedures. Therefore, it is not appropriate or conscionable for the Federal Government or others to really be paying for these overpriced procedures.

The other concern that we have and are addressing is to diminish inappropriate utilization. That represents a significant cost in dollars, but it also exposes our citizens to the dangers of unnecessary procedures. We are trying to diminish inappropriate utilization, and also to reduce the costs of those procedures. But it is certainly not to pass on additional costs to the beneficiaries.

Senator EXON. I think your intentions are well founded. I just would point out that premiums continue to go up, especially for the elderly, the disadvantaged and the handicapped, very dramatically. While it would be well to assume that these costs would not be passed along to the present recipients, because we are going to make a saving by reducing the fees of the practitioners, I suspect that when we add all this up, the sum of savings is not going to equal the total that we anticipate.

My time is up. Thank you, Mr. Chairman.

Chairman **Sasser**. Thank you, Senator Exon.

Senator Bond.

Senator **Bond**. Thank you very much, Mr. Chairman. I have a statement that I would like to submit for the record.

Chairman **Sasser**. It will be included in the record.

[The prepared statement of Senator Bond follows:]

STATEMENT
SENATOR CHRISTOPHER S. BOND
SENATE BUDGET COMMITTEE

DR. SULLIVAN, IT IS A PLEASURE TO HAVE THIS OPPORTUNITY TO HEAR YOUR THOUGHTS ON THE MANY HEALTH CARE ISSUES FACING US TODAY.

THE CHALLENGES YOU FACE ARE ENORMOUS. NOT ONLY IS YOUR DEPARTMENT RESPONSIBLE FOR SOCIAL SECURITY, MEDICARE, AND MEDICAID AMONG OTHERS, BUT YOU ALSO HAVE THE TREMENDOUS RESPONSIBILTY OF DEALING WITH THE ONGOING AIDS CRISIS.

I CERTAINLY WISH YOU LUCK, AND STAND READY TO ASSIST YOU IN ANY WAY I CAN.

TODAY'S HEARING FOCUSES ON THE FASTEST GROWING PROGRAM IN THE FEDERAL BUDGET -- MEDICARE. FROM FY80 TO FY90 IT HAS GROWN NEARLY 200%, AND ITS ACTUARIES PROJECT THAT IT WILL BECOME THE LARGEST FEDERAL PROGRAM -- DWARFING BOTH SOCIAL SECURITY AND DEFENSE -- BY THE YEAR 2010.

MEDICARE SPENDING FOR THIS FISCAL YEAR IS EXPECTED TO REACH 86.8 BILLION DOLLARS, AND PRESIDENT BUSH IN HIS BUDGET REQUEST FOR 1990 HAS REQUESTED AN ADDITIONAL $8 BILLION -- AN INCREASE OF 9.2%.

OUR JOB NOW IS TO DETERMINE WHAT LEVEL OF FUNDING IS NEEDED TO INSURE THAT THE MEDICARE PROGRAM HAS SUFFICIENT FUNDS TO HANDLE ITS RESPONSIBILITIES, AS WELL AS RECTIFY SOME OF ITS CURRENT PROBLEMS.

MEDICARE ACCOUNTS FOR 46.2% OF THE INPATIENT STAYS IN MY STATE'S HOSPITALS, AND THUS IS FAR AND AWAY THE SINGLE LARGEST PAYER. HOWEVER, OVER HALF OF OUR HOSPITALS ARE CLASSIFIED AS SMALL (MEANING THEY HAVE LESS THAN 100 BEDS) AND MANY OF THOSE ARE IN RURAL AREAS. UNFORTUNATELY IT IS THESE RURAL HOSPITALS THAT ARE IN THE TOUGHEST SHAPE FINANCIALLY, AND ARE THE ONES MOST SUSCEPTIBLE TO REDUCTIONS IN MEDICARE PAYMENTS.

AS A MEMBER OF THE SENATE RURAL HEALTH CAUCUS I HAVE A STRONG INTEREST IN REVERSING THE DECLINE OF OUR RURAL HOSPITALS. MORE THAN HALF OF THE RURAL HOSPITALS IN THE MIDWEST LOST MONEY LAST YEAR, AND OVER 20 PERCENT OF THE COUNTRY'S 2700 RURAL HOSPITALS ARE PROJECTED TO CLOSE OVER THE NEXT SEVERAL YEARS.

IN MANY CASES THE HOSPITALS ARE THE ONLY SOURCE OF ACUTE CARE IN THE AREA -- SO MY QUESTION TO DR. SULLIVAN AND THIS COMMITTEE IS SIMPLE -- ARE WE COMMITTED TO DEVELOPING A PLAN TO RESOLVE THE RURAL/URBAN REIMBURSEMENT ISSUE?

I SUPPORT ELIMINATING THE DIFFERENTIAL, I HOPE MY COLLEAGUES DO AS WELL.

SOME MAY ARGUE THAT THE FINANCIAL DIFFICULTIES OF RURAL HOSPITALS ARE CAUSED BY A VARIETY OF FACTORS -- AND THAT THE REIMBURSEMENT IS SIMPLY THE MOST VISIBLE. HOWEVER, GIVEN THE MAGNITUDE OF THE PROBLEMS AND THE EXTREMELY LOW MARGINS UNDER WHICH MOST RURAL HOSPITALS OPERATE, I BELIEVE WE NEED THE ADMINISTRATION TO AT LEAST DETERMINE THE EXTENT OF THE THE DAMAGE CAUSED BY THE LOW REIMBURSEMENTS.

UNFORTUNATELY, THE UNCERTAIN FINANCIAL STRENGTH OF RURAL HOSPITALS, ALONG WITH THE CLOSURES THEMSELVES, HAS CREATED YET ANOTHER PROBLEM -- RECRUITING AND RETAINING PHYSICIANS AND NURSES HAS BECOME EVEN MORE DIFFICULT.

A RECENT SURVEY OF MISSOURI HOSPITALS SHOWED THAT IN 1988, 8.5 PERCENT OF ALL BUDGETED REGISTERED NURSE POSITIONS WERE VACANT. HOWEVER, IN MANY RURAL AREAS, THE VACANCY RATE WAS RUNNING OVER 14 PERCENT. I HOPE DR. SULLIVAN WILL DISCUSS THE ISSUE OF SUPPLEMENTAL REIMBURSEMENTS FOR THOSE HOSPITALS OPERATING IN AREAS SUFFERING FROM EXTREME MANPOWER SHORTAGES.

AND I WOULD ALSO HOPE THE ADMINISTRATION WOULD DISCUSS ANY THOUGHTS THEY HAVE ON DEALING WITH THE RURAL ASPECT OF THE NURSING SHORTAGE.

DR. SULLIVAN, I LOOK FORWARD TO YOUR TESTIMONY.

Senator **Bond**. Mr. Secretary, we are delighted to have the chance to talk with you today. I have some real concerns about rural health care. According to a Missouri Health Association study, medicare patients account for about 46.2 percent of inpatient days, and they are, therefore, the largest single payer of Missouri hospitals.

Now, over half of our hospitals in Missouri are small; that is, under a hundred beds. Many of these are in rural areas, and these hospitals have lower net income than urban hospitals, small or large. More than half of the rural hospitals in the Midwest lost money last year, and more than a fifth of the Nation's 2,700 rural hospitals are projected to close by 1990. In many instances, these hospitals are the sole source of acute care for the residents in surrounding areas.

Do you believe that we should be working to eliminate the reimbursement differential between urban and rural hospitals? And is the administration willing to devise a plan to eliminate that differential?

Secretary **Sullivan**. Thank you for your comments and that question.

The department have been addressing that issue and made some progress, though not as much as is needed, towards closing that urban/rural differential. We are concerned about the problems of rural hospitals. I believe it was in September of 1987, the Department established an Office of Rural Health Policy. That office is charged with looking at the problems of rural hospitals and making recommendations to the Department.

The President's budget contains a recommendation for doubling budget for that office. It is a relatively modest office, but I believe that it is going from $1.5 million to $3.1 million for the operations of that office in monitoring our rural hospitals.

Senator **Bond**. I commend you for the initiative to build up the office. I hope that some of that money can get out to the rural hospitals, because we do need it there.

The uncertainty of hospital finances is making it difficult, in addition, for rural communities to recruit and retain physicians and nurses. A survey of Missouri hospitals during 1988 showed that 8.5 percent of all budgeted positions for registered nurses were vacant. We all know the difficulty of getting physicians to practice in rural areas. In some areas, the vacancy or unfilled position rates are even higher.

Do you favor additional reimbursement for physicians practicing in rural areas where there are manpower shortages? If so, how would that be done, and does the administration have any plans to address the other but very acute problem of the national nursing shortage as it affects rural areas?

Secretary **Sullivan**. Yes, we are concerned about the distribution of health professionals in under-served and rural areas.

First of all, the ongoing activities of the Department, in terms of placement of physicians in the National Health Service Corps, is focusing on placing those available physicians who have a service obligation to us in rural areas.

Secondly, the proposal to increase the reimbursement for primary care services that is in the President's budget will help the problem of rural, as well as inner city, primary health needs. Most of the need for rural hospitals really falls in the area of primary health care. We will continue to address this problem and come up with some additional solutions.

The nursing shortage problem, of course, is one that, again, we are also concerned about. Secretary Bowen's Commission on Nursing reported last December on this issue. They made a number of recommendations which are now being evaluated by the Department. Among them are continued support of the nursing scholarship program and changing the service patterns of the nursing staff. In other words, to free them up from some of the administrative and paperwork tasks, so that they can spend more time at the bedside of the patients.

Some other recommendations include changing the professional image of nursing to make it a more attractive profession to young people.

Again, it is a significant and serious problem and one that is going to require some attention over time to address in an effective way.

Senator BOND. Another factor that is contributing to the physician shortage in rural areas is the tremendous cost of malpractice insurance, up to $100,000 per physician or more, usually, in obstetrics. Because of the lower overall reimbursement rate, rural hospitals again have problems absorbing that. Is there any effort within your Department to study the malpractice insurance problem or recommend solutions?

Secretary SULLIVAN. Yes; this has been an ongoing problem. I know Secretary Bowen spent considerable time and effort developing approaches to the malpractice problem because of the obstetrical problems that you have outlined. I think in almost every State, and certainly in my State of Georgia, we have a number of rural areas that have no obstetrical physicians because of this problem. This, again, continues to be an ongoing problem, one that I think will require multiple solutions, including using nurse midwives and utilizing major centers in a much more comprehensive way. This is a problem that concerns us, and we are looking at that in the Department.

Senator BOND. Thank you, Mr. Secretary. Thank you, Mr. Chairman.

Chairman SASSER. Thank you, Senator Bond.

Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman.

Again, welcome, Secretary Sullivan. I, too, was very pleased by your nomination by the President. I have high regard for you, and I look forward to working with you in the days ahead.

I wanted to follow up just for a moment on a statement you made that the President has a commitment to keeping the promise on social security. Given the fact that his budget proposal assumes that we will spend the social security surplus that is suppose to be put aside for the baby boom generation, how is he going to keep the commitment for the future when the money is gone?

Secretary SULLIVAN. It is my understanding, Senator Conrad, that we are allocating those funds to the trust fund. We have a commitment to preserve the solvency of those funds. I know one of the issues that concerns us is the fact that trust funds are now included in the overall Federal budget, and used when looking at the deficit issue. In time, I believe in 1993, will go off budget so that they will no longer be utilized in calculating the overall deficit.

We are committed to maintaining the solvency of these trust funds and to keeping the commitment that we have made to our citizens that those funds would be available to them in their retirement years.

Senator CONRAD. Well, I understand what you are saying. I am just perplexed on how we keep a commitment when we spend the money that is supposed to be set aside. What we are doing would not bear scrutiny in any private sector enterprise I know of. The funds we are spending are the funds that are supposed to be set aside for the future, and we are playing an enormous game. We need to stop it, in my judgment. We need to be honest with each other and the American people. The money that is going into the trust fund is an IOU. The money is gone. And I think that is a serious matter.

Let me get into an other matter that follows up on Senator Bond's comments. We just had a series of Senate Budget Committee hearings in North Dakota on the question of health care. I want to just read to you from some of the testimony we received. This is from Gordon Smith, who is the administrator of the Dickey County Memorial Hospital in Ellendale, North Dakota. Eighty-two percent of their inpatient days are medicare, and that is true of many of the rural hospitals in my State—disproportionately medicare because of the aging of our population.

Here is what he wrote:

> Let us say it is 1991 or 1992. The doors to this hospital were locked yesterday. It has gone the way of the rural hospitals, closed because it could no longer pay its creditors due to the heavy reliance on medicare reimbursement. I physically turned the key on the front door. I did so only in a physical sense, knowing that it had been efficiently operated. The real or actual parties turning the key were in Washington and Baltimore. The physicians have already left the community because they needed a hospital for their patients. Yet I wonder about the elderly neighbor. The ambulance is parked at the front of his home. Will he be alive when the ambulance reaches Aberdeen or Jamestown? But that is now the way it is to be for all rural residents, young and old. Once, health care was accessible to us. Today, we live with less and only memories of the past and the benefits that were once ours.
>
> As the ambulance pulls away from the neighbor's house, I think back to 1989. Maybe I should send a copy of my testimony to those on the current Senate Budget Committee. Perhaps it would help some other small rural hospitals who are on the brink.

There is one other bit of testimony I want to share with you, because it was moving to me and persuasive, and I would like to share it with you.

This is from a Dr. Ketterling who practices at the Good Samaritan Hospital in Rugby, North Dakota. "In 1988, the total medicare discount absorbed by Good Samaritan Hospital in Rugby was $678,000. In the month of July, we lost $56,000 on just four patients, $100,000 on a single patient in October. If a person dies in 13 hours, you get paid the same as if they stayed 13 weeks. Death has become the most cost effective treatment."

Now, I wish you could have been with me and heard the testimony, rural hospital administrator after rural hospital administrator saying this is simply a question of access. If we do not change, these rural hospitals will cease to exist.

My question is: Have you had a chance to study the Bentsen-Dole bill? And if so, have you had a chance to take a position on it?

Secretary SULLIVAN. Thank you, Senator Conrad.

I have not had an opportunity to study the Bentsen-Dole bill, although I am aware of its concern for rural hospitals. We will be looking at that bill as soon as we can.

We are very concerned about the problem of rural hospitals. A number of these hospitals have low occupancy rates, averaging 40 percent for the rural hospitals. Among the things that we are doing and reviewing in the Department, in addition to, placement of corps physicians in rural areas, is a possible restructuring of some of these facilities, and enhancing ambulatory activities. As I indicated, we are increasing the personnel in our Office of Rural Health Policy in the Department to more closely review that problem.

We are aware of the problem in North Dakota, as well as a number of other States, and we are going to do as much as we can to address this complex problem. It is not simply a reimbursement matter but it is also a question of the appropriate size and configuration of such facilities.

Senator CONRAD. Mr. Chairman, if I might, I have a number of questions that I would like to submit in writing for response from the Secretary.[1]

Chairman SASSER. Very well.

Secretary SULLIVAN. I will be very pleased to respond.

Chairman SASSER. Thank you, Senator.

Mr. Secretary, on the whole question of the 37 million people who have no medical insurance coverage at all, does this administration have a legislative proposal to help these 37 million uninsured, whether through a medicaid buy-in provision or other means?

I ask that question because during the campaign of 1988, then candidate Bush was discussing the whole question of the problem of the 37 million who were uninsured and indicated that those with incomes too high to qualify for medicaid, although still medically indigent, so to speak, would be allowed to buy into the medicaid program, through premiums or through copayments. And he also hinted that this might start with the highest priority, and that is children.

What is your response? Does the department at this juncture have any plans to try to move forward with a buy-in expansion of the medicaid program?

Secretary SULLIVAN. Yes; Mr. Chairman. We are, along with others in the administration, reviewing this issue, and I can assure you that it will be addressed.

As you know, the President already has proposed expanding the medicaid program by increasing the eligibility for individuals up to 130 percent of the poverty level for mothers and their children.

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[1] See p. 231.

We are concerned about the problem of the 37 million uninsured. Federal and State governments, as well as the private sector will need to formulate a comprehensive plan that will make a reasonable dent in this problem. It is a very costly and complex problem but we will be addressing it and encouraging others to come up with initiatives to help address it.

Chairman **Sasser**. Does the Department have any view on the whole question of mandated health insurance benefits? I ask that question in this context: I am having a number of business people voice the view to me that they feel they are being unfairly penalized for furnishing their employees health insurance, since those with health insurance are being asked to defray the costs of those who are treated by hospitals without health insurance.

For example, hospital administrators are telling me that we are losing money on Medicaid. I am not vouching for the veracity of these statements; I am just telling you what some of them are telling me. I have no reason to doubt their truthfulness.

But they are losing money on medicaid. They are either not making any money on medicare; they are breaking even or they are losing money on medicare. They are treating charity patients, for which they receive little or no compensation. So they make it up by overcharging those patients who are insured or those patients who can afford to pay.

Now, business people who furnish medical insurance to their employees are wising up and they are realizing that this very fast-growing part of their overhead known as health insurance premiums, the fringe benefit for their employees—they are not only giving a fringe benefit for their employees; they are also subsidizing the employer down the street to some extent who does not furnish health insurance for his employees.

Does the department have a view on the whole question of mandated health benefits at this juncture?

Secretary **Sullivan**. Senator Sasser, we are concerned about the large number of citizens who do not have insurance, and we will do everything we can to help increase the number of individuals receiving coverage.

We don't believe, however, that the best approach is a Federal mandate. We believe that this will require some private sector initiatives to increase the availability of insurance to those individuals, as well as activities by State and local governments.

The issue of the costs, were there to be a Federal-mandated program is a very serious one. We believe the best approach, particularly in view of the Federal budget deficit would not be a mandated federal program.

Chairman **Sasser**. Senator Exon.

Senator **Exon**. Mr. Chairman, thank you very much. I just have one question. I must go to the floor.

And thank you once again for being here, and you have been very enlightening on some matters, Secretary Sullivan. I just want to emphasize once again that throughout rural America today, unnoticed to a large extent in the Nation's larger cities and probably in Washington, there is a general and a very steady loss of health care services and closings of hospitals.

I want to ask a general question. Do you or the administration at this time have any strategy to maintain these services that you said in your opening remarks were important because in a city, if we have too many hospitals, parts of them can be closed or maybe some of them can be closed without any significant reduction—a reduction maybe in convenience, but without a serious reduction in the overall health care delivery system in a city?

That is not true with an extremely rural area in Nebraska or North Dakota or other places that have been mentioned here this morning. I am suggesting just maybe we should have a rural health care initiative by the Administration, recognizing the needs in the rural communities of the United States.

Let me put it this way: You show me a rural city without a hospital and I will show you a rural city without a doctor. Now, maybe that could be changed with some initiatives. Maybe through our training facilities in our medical schools, we could get away from the status quo that you train everybody essentially in the same fashion until they get into their specialty.

When I was Governor of Nebraska, we initiated a program through, and had good cooperation from our medical schools, with regard to more emphasis on family practice, for want of a better term, as we called it—another way of saying just primary care through family practice is critically important to the less populated parts of our society in the rural States.

Physicians' assistants have filled in the gap to some extent in some areas. I guess, though, that if we are going to maintain a reasonable quality of life, which no one can describe that today without saying medical care is a part of it—and we do not expect in rural America that we are going to have all of the facilities and all of the treatments and all of the specialists to do all of the things that they can at Johns Hopkins.

I am saying that I am fearful that we are missing the boat on some of these things, and I am wondering if a rural care initiative would not be a good idea both from the standpoint of what is right, but also a rural health care initiative may, in the end, save us some taxpayer dollars.

Secretary **Sullivan**. Thank you, Senator Exon. Let me say this. First of all, we do believe that we need to change the kind of training physicians are receiving, and that is shared elsewhere.

You may be aware that only a few days ago a committee in New York City headed by Dr. Alfred Gelhorn of the health department, involving all of the medical schools and the teaching hospitals in New York, pointed out that: New York state has 15 percent of all residency training programs for physicians in the country, but that the aggregate of those hospitals, which are some of the finest hospitals in the Nation, were emphasizing much too much training of specialists.

They needed to indeed train more physicians in primary care, and this is the situation that is repeated in virtually every metropolitan area around the country.

Certainly, I think that Nebraska and other States have taken the lead over the years in emphasizing the need to shift the training patterns towards more primary care physicians.

We don't need neurosurgeons in a town of 500 people; we need family physicians who can take care of 90 percent of the medical ailments that people have. The change in reimbursement patterns for primary care that the President has proposed will help. We have to be able to provide payment for the services that are needed.

Certainly, a rural health initiative is something that can be reviewed by our Office of Rural Health Policy. We have a program to support the development of regional rural centers. A facility that serves a certain geographic area may very well be shown to be critical, and thus qualify for special initiatives.

We are very willing to review at any number of approaches to try and assure that access to health care does remain, while at the same time recognizing that we do have a system that does have excess capacity. We cannot afford this. It is inappropriate, and we need to get rid of it.

Senator Exon. Thank you very much. I have a few additional questions I will submit for the record,[1] Mr. Chairman, and I just say to you that I believe that if we are going to make the changes to emphasize quality health care for rural America, recognizing that we can't have everything, I believe that that initiative, maybe with some funding restraints or dictate tied with it that flow out of Washington, D.C., to the whole medical community, including research, including training of physicians that is critically important, we are going to have to have some directive from Washington.

And I suggest that while Nebraska and other States have furnished some lead in this area, they don't have the enforcement hammer that is necessary to have it looked at more realistically, and maybe a health care initiative is an idea for rural America that you could pursue and look at further.

Thank you very much.

Chairman Sasser. Senator Simon.

Senator Simon. Thank you, Mr. Chairman, and I want to welcome Secretary Sullivan to this committee. I have known the Secretary for some years and I think the President is to be applauded on his appointment.

Having said all those good things now, let me ask, is the cut in medicare driven by the status of the Medicare Trust Fund or by the desire to keep the deficit down?

Secretary Sullivan. Thank you, Senator Simon, for your kind remarks.

The changes in medicare funding represent an increase of some $8 billion in 1990 over the 1989 level. What we have is a restraint in the rate of growth in that program because if the current rate of growth of some 14 or 15 percent annually, were to continue we project that by the year 2000, it would double. We simply don't have the funds to support that level of growth.

At the same time, we see this growth when we do have excess capacity in the system—a 60-percent occupancy rate in our urban hospitals and a 40-percent occupancy rate in our rural hospitals.

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[1] See p. 227.

There has been a shift from in-hospital to ambulatory care, which I support and applaud, and it means that perhaps what was needed 20 years ago in terms of in-patient facilities, is not needed now, we cannot afford to support unnecessary care. We need to release those funds and target them into other areas where they are needed.

The President's budget is designed to restrain spending. We also have, as far as physicians are concerned, around a dozen procedures that have been identified by the Inspector General as being over-priced. We want to get these costs in line, as well as remove any incentive for procedures to be done that are not appropriate.

We are trying to provide the services that are needed, but at the same time restrain the growth in our budget, because it has been excessive. America has the highest percentage of the gross national product going towards health care of any of the industrialized nations. Yet, our health care is not first in terms of indices, such as infant mortality.

Senator SIMON. I agree with the latter part of your statement completely, and I think one of these years, and it won't happen this year, we are going to have to take a hard look at the overall picture of where we are going in health care.

Each of us up here is a little bit provincial; you will find that. But sometimes by looking at our own State, we get a fair picture of what is happening in the universe out there.

You are correct when you say there is an increase in Medicare funding. If we were to keep at current policy levels, it would be another $5 billion. That cut is one that will affect most of those hospitals as far as the part A funding, those hospitals that serve primarily the least fortunate.

When you look at Illinois, we have had 32 hospitals close in the last 8 years. The State of Texas—I don't see Texas represented here right now—has had 81 hospitals close.

And you ask where are they closed? Well, the rural hospitals. The poorest area in our State is around Carroll, Illinois. The Carroll Hospital has closed. You look in the city of Chicago; the hospitals that have closed are on the west side of Chicago, on the south side of Chicago—the poorer sections.

And my fear is we are accelerating that trend with this kind of a cut. I had a breakfast recently with someone who is in a responsible health care position in Illinois who said three hospitals serving Illinois' inner city poor are very close to closing.

Any comments on what the impact of this $5 billion cut would be in terms of who is really going to feel the impact of that?

Secretary SULLIVAN. Well, Senator Simon, it is difficult to answer that precisely, but from my own experience in Atlanta, we had a hospital close more than a year ago that was in the inner city and served the low-income and minority population.

It was a 140-bed facility, but the impact on the community was negligible because there were many other hospitals available right in that area which have easily taken up the slack.

I would say that in Atlanta we still have excess capacity. The problem is, unfortunately, many hospitals or hospital administrators all want to have 500-bed facilities with nuclear magnetic resonance facilities, cardiovascular surgery, et cetera.

Efforts to avoid unnecessary duplication in the system have not been very successful. We find that costs have escalated when a facility purchases a duplicative nuclear magnetic resonance machine or sets up a team in cardiovascular surgery which is underutilized.

We are very much concerned with providing access to health care for the poor and minorities, but every facility that closes doesn't mean that those populations are necessarily going to be adversely affected. Instead we need to have funds available for the WIC program, Head Start, and implementation of welfare reform legislation, as well as other parts of the health care system.

It really is a difficult process of adjustment that we have to go through in order to husband most effectively the dollars that we have and provide the services to the population that are most needed.

Senator SIMON. Thank you. Thank you, Mr. Chairman.

Chairman SASSER. Thank you, Senator Simon.

Senator Nickles.

Senator NICKLES. Mr. Chairman, thank you very much.

Secretary Sullivan, welcome to the committee. I apologize. I wasn't able to catch all of your opening comments, but I have read most of your statement. I know I have received some comments from Oklahoma hospitals. As a matter of fact, I have met with representatives of most all of Oklahoma's hospitals in the last couple of months. Many expressed concerns about—well, they used the terms cuts in medicare.

How much is the medicare function total expenditure rising between 1989 and 1990 in your budget?

Secretary SULLIVAN. There is an increase of $8 billion over the 1989 budget.

Senator NICKLES. What is that, percentage-wise?

Secretary SULLIVAN. It is almost a 10-percent increase.

Senator NICKLES. About a 10-percent increase. So, actually, government expenditures in medicare will be increasing by 10 percent between this year and next year if your budget would go forward?

Secretary SULLIVAN. Yes.

Senator NICKLES. Now, the cuts that have been discussed—is that from, what, a CBO-projected inflation? Were expenditures estimated to increase at, what, 14 percent?

Secretary SULLIVAN. Yes; it is around 14 percent if they were not restrained.

Senator NICKLES. If there was no restraint, if we did current services? Is that the terminology?

Secretary SULLIVAN. That is correct. What we are trying to do is, provide the services that are needed, but to rid the system of the excess capacity.

Senator NICKLES. Well, I am trying to figure out how it applies to a medium-size hospital in Atlanta or Oklahoma City or Tulsa or something like that. Is that hospital going to receive more money than it received last year under these proposals, less money?

Most of them are acting like they are going to have a significant reduction in monies next year from what they received this year, and I just question that a little bit. If total expenditures are rising at 10 percent, which is about two times, or a little over two times what the expected inflation rate is, where is the cut?

Senator DOMENICI. Would the Senator yield before the question is answered?

Senator NICKLES. I will be happy to, but I have a couple of other questions.

Senator DOMENICI. Just to clarify something.

Senator NICKLES. Sure.

Senator DOMENICI. I believe out of the 10 percent growth, to be fair, there is a certain percentage that is for additional beneficiaries which is automatic. You have got to cover those eligible. Isn't that number about 2 percent?

Secretary SULLIVAN. Yes, that is correct, Senator.

Senator DOMENICI. So, essentially, it is an 8 percent increase in the program for inflation and other purposes, and 2 percent growth is for new people. Is that correct?

Secretary SULLIVAN. Yes, that is correct.

Senator DOMENICI. Thank you, Senator Nickles.

Senator NICKLES. Well, I appreciate the clarification.

So, to answer my question, will the hospitals themselves in rural communities, which I happen to be concerned about—and I happen to have—some of which were stated by the Senator from Illinois—we have had hospitals close in my State, and I have had a number of our hospitals say that they will close next year or the following year if something different is not done.

But I am still trying to get a better grasp on it because we do serve on this committee and we are somewhat responsible, or should be, on the fiscal side of the picture. How much money are we spending?

Will those hospitals be receiving more money next year than what they receive this year?

Secretary SULLIVAN. I think the funding depends upon the individual hospital. It is difficult to give a blanket response.

Senator NICKLES. Well, most hospitals in the country. I will make it very general. Will most hospitals in the country be receiving more money?

Secretary SULLIVAN. Yes; we are trying to restrain the rate of inflation or growth in the costs of the services in the system.

The thing that we confront with unrestrained growth, at the rate that we have seen it over the past decade, is that by 1995, we would be spending twice as much as we would be spending in 1990, which would be roughly $200 billion.

The problem that we have is that we have excess capacity. We need to eliminate that excess capacity and use those funds for other services.

Senator NICKLES. I understand. I appreciate your comment. I share some of the concerns that have been expressed by others. I want to ask you one quick question while I still have time, and that deals with the catastrophic insurance program that Congress passed last year.

I, for one, have received thousands of calls and concerns from my constituents saying that it is unfair, many of which said they already had the insurance, many of which their employers paid for the insurance—it was provided to them at no expense to themselves; many of which provided it for themselves in the private sector at a considerably cheaper or much more economical rate than what they are being mandated to do by the Federal Government.

Has your office received that type of response, or are you looking at some possible changes? Some of us have introduced legislation—I have, for one—that would postpone sections of that for a period of time to allow Congress to redirect the effort towards those persons that didn't have the insurance and who couldn't afford it instead of making it universal for many people who already had it, didn't need it, or their employers were providing it. Have you looked at that?

Secretary SULLIVAN. We are in the first year of implementation of the catastrophic program which does address a serious need. This need was identified by a number of individuals and represents a tremendous effort on the part of Secretary Bowen to address the problems individuals with serious illness face.

We feel that the program should go forward before major adjustments are made. Not all of the affected constituents have expressed displeasure with the system. Many of the elderly associations recognize that this addresses the need and support it.

Senator NICKLES. I want you to be aware of the fact that there is a very large community out there that is quite upset about the expense of the program, providing for—well, 72 percent of senior citizens already had insurance, and this is duplicating that insurance.

I want you to be aware of it because I think there will be a lot of push from Congress and others to make some changes to alleviate some of the very expensive provisions of this bill.

Secretary SULLIVAN. Thank you.

Chairman SASSER. Thank you, Senator Nickles.

Senator Lautenberg.

Senator LAUTENBERG. Thank you, Mr. Chairman.

Welcome, Dr. Sullivan. I was pleased when I heard that you were going to be nominated for this post and I was pleased to vote for you in that process. And I, among many here, am excited about the fact that someone who has the kind of concerns that you have expressed in your life to this point wound up in the position that you have. We look forward to working with you.

I think you are going to make a very important contribution to the department and to the well-being generally of the country. You are going to have to do a lot of arm-wrestling along the way, and we hope that you will maintain your advocacy for the things that you believe ought to be done and resist as much as you can the kinds of cuts that would impair improving the health and well-being of the citizens of the country.

I hope that when you have the opportunity that you will support a Surgeon General appointment that is as aggressive and as forthright as Dr. Koop, who presently holds the position. And I look forward to working with someone who has the courage, as well as the knowledge, to do that job well. I think Dr. Koop has certainly exhibited that.

I wanted to ask you, in connection with health related programs about a story that we just saw in the New York Times about a group setting up a network to work with foreign doctors to import prescription drugs not available in the United States for use by AIDS victims.

Now, I understand that as of last year, the FDA has allowed people with life-threatening illnesses to import personal supplies of unapproved drugs. You are aware of how desperate the situation is for those who suffer from AIDS, and anything that looks like it might give them a reprieve from death is welcome.

All of us have had the opportunity to see people affected by AIDS, and you know that in New Jersey we have a very high number of AIDS victims. I wanted to ask you about how the FDA views this proposed plan and, how you see the FDA functioning in connection with the network to import prescription drugs for AIDS victims who want to can have these materials available to them.

Has there been a decision made on this matter, and what are the things you are going to be looking at?

Secretary SULLIVAN. Thank you, Senator Lautenberg. The Department is very much concerned about the problem of AIDS, and we are really very pleased to report that President Bush has proposed an increase in the AIDS funds for the Department of 24 percent for education and research, and I believe $700 million for treatment through existing programs. So we are committed and concerned about the AIDS problem.

The FDA has been very actively promoting faster approval of new drugs to get new discoveries out to our population much more rapidly. We have a so-called treatment IND permit for an investigational drug to be used that shows great promise of being effective.

We don't know enough about the network that has been reported recently. The Food and Drug Administration and the Department, have a responsibility to the American people, the Congress, and the President to assure that drugs that are proposed have some reasonable likelihood of being effective so we can protect our citizens against medical quackery. Even in our advanced, sophisticated society, we still have a number of instances of quackery.

On the other hand, we recognize that the AIDS situation for a number of individuals does represent a desperate situation. We don't want to impede any citizen's access to a treatment that holds some promise. We are learning as much as we can about this network. I saw the article in the Times that you referred to, and I believe some of these drugs have been approved for use in other countries and are felt to have some effectiveness. We need to have more information, and we will do everything we can to facilitate access to drugs that do show a reasonable promise against this dread disease.

Senator LAUTENBERG. Dr. Sullivan, one of the things that you mentioned in your comments was the fact that President Bush had requested $1 billion on the research side of things.

On the other hand, I think it is important to note that Secretary Bowen recommended $1 billion for that account. He said it was necessary to have that kind of funding to really fight the war on AIDS, and I wonder whether you would want to comment on that.

Secretary SULLIVAN. The $1.6 billion represents a 24-percent increase in AIDS funding If you review the last 3 or 4 years, there has been a very substantial increase in the AIDS funding.

This is an area that is rapidly evolving—a lot of research is going on at NIH and at medical research institutions around the country, to improve our educational and preventive programs. A lot of the issues, are controversial, such as, in New York, the health commissioner has proposed providing clean needles to drug addicts, because that is the most prevalent route of transmission in New York.

However, the health authorities in New York are faced with the threat of prosecution by the district attorney because, as you know, you have to have a prescription to have a needle and syringe in the State of New York.

There are a lot of other issues that have to be resolved regarding the appropriate preventive strategies that are available for AIDS. We think that while there was a request for more funds we nevertheless have had significant increases over the last several years.

Senator LAUTENBERG. Mr. Chairman, I know that my time is up. I would like to be able to submit some questions for the record to Dr. Sullivan and would ask for as prompt a response as you can give us. The questions deal with the targeted assistance funding under the Office of Refugee Settlement.[1]

Thank you very much, Mr. Chairman. Thank you, Dr. Sullivan.

Secretary SULLIVAN. Thank you.

Chairman SASSER. Thank you, Senator Lautenberg.

Senator KASTEN.

Senator KASTEN. Mr. Chairman, thank you very much.

Dr. Sullivan, welcome. I would like to touch on a question that Senator Lautenberg was just touching on with regard to the Cuban refugees, and look at the issue in a slightly broader context.

As you know, we have had an unusual increase in immigration of all kinds, legal and illegal, into this country, particularly a huge increase in Soviet Jews that have been recently released from the Soviet Union. These jews are processed in Vienna, come down to Rome, and at that point are processed by the State Department, by INS, and then as refugees they come over here.

Once they are over here, they come under HHS programs and certain kinds of match programs with a number of private voluntary agencies to, help them make the transition into our society. So it is a combination of INS, State Department, and your department.

Let me ask you a question. In these refugee programs, do you believe that you have adequate funds to process the increased number of refugees that are now expected? Do you have enough money to make it through, in your view, to the end of this fiscal year?

Secretary SULLIVAN. Thank you, Senator Kasten. This is an area, that I have not yet had an opportunity to review closely, and I really can't give you a response today. But what I would be more than happy to do is to take this question back to the department and consult with my colleagues.

Senator KASTEN. Well, Dr. Sullivan, the answer to my question is you don't, and that is why I was asking it. In a sense, you don't have the money to match what will be put up by the private voluntary agencies particularly with regard to the Soviet Jews, the Armenians, and others.

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[1] See p. 229.

It is likely that you will be out of money, my guess is, some time between Easter and Memorial Day. What we have got here is an emergency situation. We have got a backlog in Rome right now of 5 and 6 weeks before they are processed.

That is not part of your problem; that is part of INS and State. But when they get here, you are also about to be out of money.

Last year, you were expecting one number of refugees and State was saying that we were going to bring another number in. And so you have got a 6,000 number that is in dispute. It is not clear how that is going to be worked out, and I just would like, if I could, to work with you and your people.

We have had a couple of people that have been working in this area in my office within the last week, but we are going to need your attention, along with Secretary Baker and Attorney General Thornburgh, in order to work this all out because what we have got is the potential for, if not a real embarrassment for the United States.

After working for years to pressure on the Soviet Union, in particular, we see the Soviet Jews being allowed out, we now, in INS, in State, and in HHS, don't have the program in place to take care of the people that we have been working so hard to get out.

I don't know whether Gorbachev is going to be in power a year from now, or whether the policies that he is pursuing right now with regard to immigration are going to be enforced then or not. But right this minute, we have got an opportunity, and right this minute we have got a responsibility and you are a key part of making sure that this process works, and I look forward to working with you.

Secretary SULLIVAN. Thank you, Senator Kasten. We will certainly look into this question, and I look forward to working with you to address it. Thank you.

Senator KASTEN. Thank you. Mr. Chairman, thank you.

Chairman SASSER. Thank you, Senator Kasten.

Mr. Secretary, past reductions in payments to physicians by Medicare have angered physicians, but they have not resulted in any significant reductions in the growth of expenditures for physician services.

I am told that the actuaries in the Health Care Financing Administration automatically discounts by 50 percent savings estimates when they are cutting payments to physicians because they figure that the physicians will make up 50 percent worth by what is characterized as gaming the system or by inceasing volume. They will find a way to get around the reductions and will still frustrate 50 percent of the savings.

Now, most analysts feel that there will be no way to significantly control physicians' costs unless we get away from the current charge-based system and impose some sort of overall caps which will control the volume of services provided, as well as unit prices.

What is your reaction to that proposal as a physician?

Secretary SULLIVAN. Well, Senator——

Chairman SASSER. You have seen both sides of it, you know.

Secretary SULLIVAN. Senator Sasser, I really need to review that more carefully and study it before I could come up with the best answer.

On the one hand, I do believe that physicians deserve an appropriate income because of the great responsibility that attends their work, the tremendous amount of effort involved in their training, et cetera, at the same time however, the public and the American people don't owe unlimited payments to physicians.

We are concerned about abuses, because it is my position that medicine is a profession, that we have a public trust granted to us when we are granted a license to practice. Therefore, we have a responsibility to both deliver quality services to our clients, to the public, and to our patients, and also do that at a reasonable cost.

I am bothered when I hear stories about excess charges made by physicians, or really excessive incomes. But I am not sure that the answer to that is a cap on physicians' fees. I need to review that and study it more.

I share your concern that we not have physicians or any other health professionals who are abusing the system at the expense of their patients or at the expense of third-party payers.

Chairman SASSER. Well, Dr. Sullivan, in your testimony before the Finance Committee, you had some good things to say about the Department's medical effectiveness initiative. Now, as I understand it, with regard to medical effectiveness, research would find out which medical procedures have limited effectiveness and may not be cost effective or may not be worth their cost.

Can you explain this a little more for the committee here this morning, and how this whole question of the medical effectiveness initiative is going to work and what procedures might be affected, in your judgment?

Secretary SULLIVAN. Yes; Mr. Chairman. The responsibility for the effectiveness research will be in the Public Health Service's, Office of Health Services Research. They are trying to address the fact that in medicine we have a large number of things that are done for patients. Unfortunately, in a large number of these instances, we don't have hard data as to what the long-term net benefit to the patient is.

One of the areas, for example, on which we have a fair amount of information is the relative benefit of surgery versus radiation or drug treatment, in the case of breast carcinoma. In many other instances, we haven't enough data.

What the Department proposes is, the long-term outcomes from a number of procedures to try and determine whether having such things as coronary artery bypass, TPA or a number of other clot-dissolving drugs—which are very costly, do have, over a period of time, a net reduction in, let us say, coronary thrombosis or myocardial infarction, et cetera.

This is a small, beginning effort in the Department that we anticipate will be growing over time, and we certainly will be encouraging that because we want to make sure that the dollars that we spend are for procedures that are recognized do have a reasonable likelihood of benefitting the patient.

Chairman SASSER. Senator Domenici.

Senator DOMENICI. Thank you very much, Mr. Chairman.

Mr. Secretary, I am going to ask a few questions that are somewhat parochial because this is my only chance, and then I would like to talk to you about medicare quickly.

The President has indicated over and over that he desires to have appointments that are minorities, such as Hispanics. My State has about 38 percent Hispanics.

I wonder if you could just tell me in a general way, are you receiving enough, in your opinions, recommendations for qualified Hispanics for positions within your Department that are within your or the President's discretion?

Secretary **SULLIVAN**. We have some recommendations, Senator Domenici, but we would like a lot more. We are in the process of looking at various positions within our Department and are very committed to finding Hispanics, blacks, Asian Americans, and others for these positions. This is an interest and commitment that the President shares.

The President has stressed to the members of his Cabinet that he wants us to be as successful as possible in hiring minorities. We would like to have more applicants brought to our attention.

Senator **DOMENICI**. Well, clearly, I support the entire thrust. Just because I have a very, very abiding interest in Hispanics, I asked only of it, and since we have many qualified people in the Southwest that are Hispanic, I wanted to get your view.

It has been my thought thus far that the President is saying one thing, but somehow the pipeline is not quite responding yet. And I don't mean to be critical. I will just let my statement stand, and your response.

With reference to the Indian people in our country, while we have a Bureau of Indian Affairs, you also have a rather significant responsibility to the minority in this country called Indians, American Indians. We have some very serious problems.

I hope that you will devote some significant time to looking into this issue. It is probably in many respects the most deplorable in the country. We have a Navajo Nation with about 200,000 people. Believe it or not, unemployment of the adult population is not 10 or 20 or 30 percent; it is like 70 percent.

And we have an Indian Health Service that you are aware of. We very much need to do a better job of coordinating, and that brings me to an issue. The city of Gallup, New Mexico—if you have missed it, is on the national news; it was on the Today Show a couple of times last week

It is a city immediately abutting the Navajo reservation where alcohol is sold. The Navajo Nation has not made a decision to sell alcohol on their reservation—and they can, but they have decided not to. As a consequence, we have an alcoholism problem in Gallup that is out of all proportion to the country, epitomized by Navajos literally strewn in the streets on the weekend in a stupor condition. We have inadequate facilities. There is an Indian health facility there.

I have a genuine interest in this, and I don't believe the city can solve it alone, nor the State. Although in the scope of this budget hearing it obviously is not a medicare-sized problem—it is not a $100 billion problem. Still, I would urge that you consider assigning somebody that you have confidence in to work with that community and with the Navajo people.

There is some drug money; there is some alcoholism treatment money. We just cannot find even a temporary solution without all aspects of government operating. And I would ask you here today if you would look into that and see if you could find some way to be of assistance in a way that would give a little hope to that community.

Secretary **SULLIVAN**. Thank you, Senator Domenici. I assure you that we will. We are very concerned about the problems of the native American population, and certainly we will look into this and do everything that we can.

Senator **DOMENICI**. All right, I have just two other questions. One has to do with the uninsured people in this country that have no medical insurance. My State is significant in that there is no State with a larger percentage of the population that is currently uninsured.

I have a thought about the uninsured that I want to share with you. You are in charge of the community health programs, which finance literally thousands of non-profit organizations. Some of them are manned by National Health Corps people. In essence, they serve a very poor population.

I submit to you that while we are going to busy ourselves as a people with trying to find a solution to the uninsured, it surely is not the time to reduce funding for this kind of service, because most of the recipients are be uninsured.

It seems to me that since it is a primary care delivery system, that we ought to do everything we can to permit them to maximize the care.

In the President's budget, what doesn't go up goes in the freeze category; Community Health Centers are in this category. I truly believe the need for these centers is tremendous, and I urge that you look carefully at the program and satisfy yourself that it is doing a good job. I think you will find that it is.

Now, having said that, I want to ask you about medicare. You are not an expert on medicare yet, but it seems to me that sooner or later somebody in your department that is expert has to come to some conclusions about medicare that are more than just putting in a budget. We must improve some of the current methods of financing.

I have already heard doctors about what is driving costs up, and from hospitals as to what is driving costs up. And I think we have a very ironic situation because whatever it is we are suggesting that we reduce payment for, none of that reduced payment is directed at what is causing the costs to go up.

I just think we have to get to the bottom of it. We have to find out why the cost going up. Is it malpractice insurance? Is it the inordinant precautions that have to be taken because of the risks? Is it cutting-edge technology? Is it the recordkeeping that is required?

It seems to me that as I look at all of your thoughts at saving $5 billion—and I understand almost $2 billion of it is to keep current law. You get almost $2 billion by leaving in place three existing provisions. But I frankly believe somebody has to get to an analysis of what is driving the costs rather than moving around the edges with the payment we already have, such as paying hospital capital at 85 percent of costs.

I would just like a brief observation from you on that issue, if you would, please.

Secretary SULLIVAN. Yes; Senator Domenici. This is a complex problem, but there are things that we do know that are a part of the cost issue that are driving the costs. First of all, we do know that defensive medicine, because of the malpractice situation, is an integral part of that. I can't give you the percentages, but the Department is looking at this, and we can get to you our best guesses.

A part, is advances in medical technology. We have the capability of doing so many things now that we were not capable of doing 20, 30 years ago when I was a medical student. Kidney transplants were just being started at that time and now they are virtually routine. Those procedures, while they can have tremendous benefits to the individual patient—kidney transplants, liver transplants, heart-lung transplants, and others, various cardiovascular procedures, nuclear magnetic resonance imaging where we can, by noninvasive procedures, find small aberrations in our anatomy—these things do cost.

What we have done over the years is concentrate our resources on these procedures. While they are medical marvels, most people don't use these procedures.

We have neglected our primary care system. The vast majority of our medical school graduates go into a specialty, rather than a primary care field. It should be the other way around. We are training high-cost individuals. That is part of the mix as well.

Other parts of this are the costs of wages in the health care system. Again, 30, 40 years ago, people were being paid a pittance of a wage as hospital orderlies, nurses or other health care workers. We have had to correct this.

We have to increase the efficiency of those high-cost individuals, as stated in the National Nursing Commission's report; we shouldn't have a nurse spending time filling out forms when a clerk at a lower level of training at a lower cost can do it. We have to address efficiencies in the system.

Having said all of that, I know that we still don't have a handle on the whole problem. This is something we will research to determine the various components.

Senator DOMENICI. Thank you, Mr. Chairman. Thank you, Mr. Secretary.

Chairman SASSER. Senator Nickles.

Senator NICKLES. Mr. Chairman, thank you very much.

Mr. Secretary, have you announced who will be the Assistant Secretary for the Health Care Finance Administration? Has that been made public yet?

Secretary SULLIVAN. No; those negotiations have not yet been completed.

Senator NICKLES. I would urge you to move as rapidly as possible to fill that position. I have mentioned to you personally and will repeat that I think there are some serious inequities.

I am also looking at your statement, and in two or three cases you are talking about—we have already discussed Part A for hospitals, and I would concur with what Senator Domenici just said concerning getting at some of the underlying problems is sorely needed.

In looking at part B, you have stated that you want to bring about improved equity in the payment level for services. You also mention that part B benefit costs have increased at a rate of 17 percent per year for the last 8 years. That is a phenomenal rate of increase. You also mention that medicare part B is a very complex program. No overall approach has yet been identified for controlling the costs. And you also again mention the need for equitable payment.

I have had a lot of meetings with constituents and found that there is a real concern within the physicians as far as the inequities are concerned. I will give you one example. In a small town, Kingfisher, Oklahoma, the President of the Oklahoma Medical Association was being reimbursed for an office call $9.50.

A younger physician just graduated out of medical school, just moved into the community, did not have a profile, and his reimbursement for an office call was $22.50. We had a physician that was in town for a few years and he was somewhere in between, $14 or $15. I find that to be totally absurd and very troublesome. And what it is leading to is really declining quality in rural health care, the urban/rural discrimination.

I will give you another example. In one town, El Reno, just outside of Oklahoma maybe 25 miles, one physician has services in El Reno, Oklahoma, and in Oklahoma. In one place, he is reimbursed, I believe, in El Reno something like $14 for an office call, and in Oklahoma City it is $21—same physician.

I am assuming, and I would be, I think, correct, the same quality of services in both places, but this is what we are getting with the profiles and the massive bureaucracy that we have in HCFA that really needs to be reformed.

I think the fact that the continual escalations of these kinds of percentages shows that the system really needs a thorough overall, and I just encourage you, one, to make that appointment as rapidly as possible and, two, to really look at it, reshuffle the cards, and maybe you will come up with a flat payment system for office calls and other services, and come up with some other type of system, total.

I think you need to step that far back and reexamine it, and I think Senator Sasser, the chairman, mentioned some people were talking about that. I would hope that you would do it.

The discrepancies between urban and rural, the discrepancies even in the same communities because of the different profiles, is very inequitable and needs to be addressed, and I just urge you to do that as quickly as possible.

Also, you mentioned the medicare economic index. Can you tell me what the medicare economic index is forecast to be for 1990, 1991, and 1992, and how rapid they expect those costs to increase over the next 3 years?

Secretary SULLIVAN. I think I would have to get that response back to you, Senator Nickles. I will be happy to do so because I don't have those figures immediately here.

Senator NICKLES. I would ask that you would do that, and also begin, because a lot of these physicians have had increases due to this index, or the hospitals have, and so on. And I think in many cases they are perpetuating and increasing inequities because there are significant reimbursement differentials with hospitals, significant differentials within physicians, as I have already mentioned.

And if you are giving the index, I guess, increase, whether that is 4, 5, 6, 7 percent, wherever it is, you are perpetuating and, in many cases, extending and exacerbating those inequities.

So, one, I want to know what the index is estimated to be, but also I think the whole system really needs to be thoroughly reexamined. I have made this approach to you privately, and I can tell you, if you are looking at the total cost in medicare—and we are wrestling with how to pay for it, and you will be, too—I think you will agree that there are some serious problems.

[The following was subsequently supplied for the record by Secretary Sullivan:]

MEDICARE ECONOMIC INDEX

The Medicare Economic Index (MEI) is forecast to be 4.70 percent in 1990, 4.60 percent in 1991, and 4.30 percent in 1992.

Senator NICKLES. One additional comment. I mentioned catastrophic and you said, well, let us give it a shot. I understand that, but as a person who is concerned about those senior citizens that are paying the bill—and in many cases, we are looking at $800 or $900 this year; next year, $1,000 per couple. Next year, you are talking about $2,000.

Actually, for 1990, it is estimated that the medicare catastrophic bill that was passed last year will be running a surplus of $5 billion, and I think it is unfortunate and unfair to ask senior citizens to be shouldering that type of excessive taxation to provide a benefit that such a small percentage will ever receive. So, again, I hope you will look at that as well.

Thank you very much.

Secretary SULLIVAN. Thank you. We will, Senator.

Chairman SASSER. Do you have any further questions, Senator Nickles?

Senator NICKLES. No; thank you, Mr. Chairman.

Chairman SASSER. Well, Mr. Secretary, we appreciate your appearing here this morning. I have questions for the record that have been submitted by Senator Robb, who was here earlier, but had to leave to go to the floor.[1]

Chairman SASSER. Also, there are questions for the record that were submitted by Senator Sanford.[2]

Chairman SASSER. I may have some additional questions myself and would ask you, sir, to respond to them just as promptly as you can.

Mr. Secretary, you have got one of the biggest jobs in the country; certainly, one of the biggest jobs in this town. We wish you well in your endeavors, and wish to be of all possible assistance to you and wish you great success as Secretary of the Department of Health and Human Services. Thank you for appearing here this morning.

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[1] See p. 232.

[2] See p. 230.

Secretary **Sullivan**. Thank you, Mr. Chairman.

Chairman **Sasser**. These hearings are adjourned.

[Whereupon, at 12:10 p.m., the committee was adjourned.]

STATEMENT
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

on

MEDICARE CONTRACTOR FUNDING

submitted to the

COMMITTEE ON BUDGET
United State Senate

FOR THE HEARING RECORD

ON THE

HEALTH AND HUMAN SERVICES BUDGET FOR FY 1990

March 8, 1989

Mr. Chairman and members of the Senate Budget Committee, the Blue Cross and Blue Shield Association appreciates this opportunity to submit our written views on FY 1990 funding for Medicare's administrative operations.

FY 1990 Medicare Contractors Funding Recommendation

After analyzing the Administration's budget request for the administrative side of the Medicare program, we urge you to provide in your FY 1990 budget resolution for a funding level of $1,748 million for Medicare contractor operations. In addition, though not considered a budget outlay which must be included in your resolution, we support the Administration's request for a $100 million contingency fund to cover unanticipated costs due to factors such as changes in Medicare growth, new legislation, and other administrative initiatives.

Our recommendation represents a current services budget which is based on the Administration's estimates of workload increases due to the growing number of Medicare beneficiaries who will become eligible for services in FY 1990 and the continuing trend of Medicare beneficiaries filing higher numbers of claims for services they have received. Our proposal also provides for the funds required to meet the added costs resulting from the Medicare catastrophic coverage program, particularly for the start-up phase in preparation for prescription drug coverage which will begin in 1991.

The Importance of Medicare Contractors

Since Medicare began over twenty years ago, the federal government has turned to Blue Cross and Blue Shield Plans and several commercial insurers to handle most of the day-to-day operations of the Medicare program. This partnership, with what the government calls its Medicare contractors, has served Medicare and its 33 million beneficiaries well.

Medicare contractors are responsible for making sure that over 500 million claims for health care services are paid promptly and accurately, that calls and letters from beneficiaries and health care providers are answered properly and professionally, and that the Medicare trust funds are safeguarded from wrongful, excessive, or inappropriate payments. Nationally, Blue Cross and Blue Shield Plans handle nearly 90 percent of the Medicare benefits paid under Part A of Medicare to hospitals, skilled nursing facilities, hospices, and home health agencies. We also handle about 65% of the Part B claims for the services of physicians and other medical professionals.

Medicare contractor costs, expressed as a percentage of benefit payouts, have been extremely low. For FY 1989, contractor costs represent only about 1.5 percent of Medicare's total expenditures. And even these costs are more than offset every year by the hard, documented savings for the federal budget which contractors generate by scrutinizing claims so that Medicare only pays the proper amount for services, and only when Medicare is legally responsible for payment.

Medicare is a rapidly growing, ever-changing federal program and Medicare contractors are on the front-lines coping with annual increases in the number of beneficiaries and their health care claims in addition to the frequent and complex legislative changes that have occurred in the program. Next year alone, the Health Care Financing Administration projects that another 652,000 individuals will become eligible for Medicare benefits, bringing the total to over 33 million Americans. Total claims submitted for payment will reach nearly 560 million, for a staggering rate of 2.2 million claims for every working day. On top of this increase in claims volume, contractors have carried out numerous legislative changes over the past eight years including meeting strict deadlines for claims payment periods, implementing complex changes in the reimbursement rules for physician services, and phasing-in the Prospective Payment System (PPS) for hospital services reimbursement -- just to name a few of the dozens of program changes in recent years. And now contractors are gearing up for a completely new responsibility, the smooth implementation of the Medicare catastrophic coverage program, the most extensive change in Medicare since the program began in 1966.

Blue Cross and Blue Shield Plans are proud of their long record of accomplishment in managing and performing the many complex tasks required to serve Medicare's beneficiaries. We believe that the investment that Medicare makes each year in its contractors is one of the best longstanding examples in the federal government of an effective and highly efficient public-private partnership. Medicare contractors have had an enviable record of solid performance, always under challenging and changing circumstances and recently during tight budget constraints.

The Administration's FY 1990 Budget Proposal

The budget submitted by President Reagan in January proposed a 12 percent reduction in the basic responsibilities of Medicare contractors compared with their current spending levels. In total, the funding level proposed in the Reagan budget is $400 million below the amount recommended by the Health Care Financing Administration for next year. We are also concerned that, depending on how the flexible freeze is applied to Medicare operations that President Bush's budget might reduce this amount even further. We believe that our national commitment to helping America's seniors and the medically disabled have access to high quality, affordable health care must go hand-in-hand with an annual commitment to adequate, stable and predictable funding for the administrative side of this vital entitlement program. Without this commitment, Medicare's promise cannot be fulfilled to its beneficiaries, and other competing priorities for federal budget resources will be held hostage to the unchecked growth of burgeoning health care expenditures.

There are numerous other adverse consequences when the funding for Medicare's administrative operations fail to keep pace with the program's double-digit rate of growth and the rapid series of recent legislative reforms. We believe that the most significant consequences of underfunding would be:

- Sharp reductions in the auditing of the financial records of health care facilities such as hospitals resulting in an unnecessary and avoidable increases in Medicare program costs.

- Higher out-of-pocket costs for beneficiaries because of reductions in efforts to identify costs for which they are not liable and less vigilant efforts to contain Medicare expenditures which translates into higher annual premiums.

- Failure to comply with stringent statutory deadlines for the timely payment of Medicare claims as well as other performance standards set by Congress in recent legislation.
- Inability to respond to the growing volumes of telephone and written inquiries from Medicare beneficiaries and providers about program rules and the status of their claims.
- Risks of unacceptable delays in preparing for the implementation of the new catastrophic coverage program.

Of particular concern to this Committee, no doubt, is the added $1.2 billion in Medicare program growth which would occur if cuts are made in contractors' ability to scrutinize Medicare claims before they are paid. Contractors now perform an extensive series of IRS-like review activities to guard against erroneous or fraudulent payment from the federal budget for services for which Medicare does not cover or for which it is not legally responsible. These safeguard activities, on the average, save the federal government about $9 for every $1 invested in protecting the Medicare trust funds. Few investments made by the federal government will ever demonstrate such substantial, positive returns. Indeed, the General Accounting Office testified last week before the Senate Appropriations Subcommittee on Labor, HHS, Education and Related Agencies that cuts in Medicare contractors' program integrity activities would be "penny wise and pound foolish." At the same hearing, HHS Inspector General, Richard Kusserow, told the appropriations panel that these cuts would weaken his ability to identify and investigate those who are engaged in Medicare fraud or who are deliberately seeking ways to take advantage of the program's reimbursement rules.

Ironically, none of these hard-earned savings which are of such concern to the GAO and the HHS Inspector General are ever scored in the budget process as offsets to total Medicare expenditures. We believe strongly that this situation should be corrected so that all-important budget scoring decisions properly credit Congressional efforts to invest in prudent stewardship of the $100 billion Medicare program and proven, legitimate safety checks on the disbursements made from the trust funds.

Unfortunately, there are no easy solutions to the challenge of restraining the health care cost spiral. Blue Cross and Blue Shield Plans wrestle with the same costs problem as the federal government when it comes to our role as health care insurers to millions of Americans. But we can advise you unequivocably that investing in a strong and effective administrative operation is far superior to the alternative of exposure to billions of dollars in payments that should never have been made in the first place or disgruntled, frustrated constituents whose questions cannot be answered promptly and accurately.

The BCBSA Funding Recommendation

We recommend a total FY 1990 funding level of $1,848 million for Medicare contractor operations to keep pace with the projected 12 percent growth in the volume of Medicare claims next year, the 4 percent increase in the rate of inflation, and to meet the demands of implementing the catastrophic health insurance program.

Our recommendation is $244 million above the FY 1989 appropriated level but is about $90 million less than the Health Care Financing Administration's original proposed budget for these activities. Our recommendation is entirely consistent with the President's budget request for $228 million for activities associated with the new catastrophic coverage program, the majority of which is needed to meet the Congress' statutory directive to develop a wholly new claims processing system to handle outpatient prescription drug payments. We also agree with the Administration's proposed contingency fund of $100 million to cover the inevitable uncertainties of estimating claims volume in the future and the possibilities of additional legislative or administrative changes in the Medicare program.

Where we significantly differ from the Administration's budget is in the funding needs of the basic ongoing operations of Medicare contractors. In addition to the payment safeguard responsibilities mentioned earlier, our proposal represents a true current services estimate to process the increased volume of Medicare claims within the legislatively prescribed time periods and maintains our ability to respond promptly to the growing number of public inquiries from your Medicare constituents about this complex program.

Our estimate of the FY 1990 funding needs for the claims processing and public inquiry services performed by Medicare contractors is essentially identical to that originally proposed by the Health Care Financing Administration for maintaining current service levels to Medicare beneficiaries next year.

We certainly recognize the difficulties that this committee faces in restoring unrealistically low budget requests proposed by the outgoing Administration. And we appreciate the need to control overall federal spending, particularly for administrative resources. However, we believe that at a time when total Medicare spending is estimated to exceed $100 billion next year -- an annual growth rate of 14 percent -- that an investment in good management is prudent and fiscally responsible.

AmHS® Institute

Affiliated with American Healthcare Systems

James L. Scott
President

Statement

of the

AmHS Institute

to the

Budget Committee
of the
United States Senate

on

Medicare Budget Priorities for FY 1990

March 1989

1919 Pennsylvania Avenue · Suite 703 · Washington, D.C. 20006 · 202 293-2840

Mr. Chairman, the AmHS Institute, representing the largest network of nonprofit multi-hospital systems in the nation, would like to submit for the record our comments regarding the Medicare Budget Priorities for FY 1990.

As the Committee is well aware, each year during this decade, the Medicare program has been subjected to substantial budgetary reductions. A comparison of data from the 1982 and 1988 Reports of the Trustees of the Health Insurance Trust Fund documents that Medicare payments to hospitals have been reduced by over $53 billion from the 1982 expenditure projections.

The AmHS Institute representing the more than 1,000 not-for-profit healthcare facilities in 43 states and Washington, D.C. which comprise the American Healthcare Systems, strongly believes that continuation of these budget driven policies puts our nation's hospitals at severe financial risk. It will not be possible to cut Medicare hospital payments by an additional $3 billion, as proposed in the Bush Administration's Fiscal Year 1990 budget, without adversely affecting both the quality and accessibility of hospital care in many areas of the country. We urge the Congress to reject the Medicare hospital payment reductions included in the new Administration's budget.

In considering this recommendation it is important to examine the cumulative effect of: 1) recent reductions in Medicare payments for hospital services, 2) reductions in Medicaid payments for hospital services, 3) increasing competitive pressures in the private market resulting in less ability to shift costs, and 4) the increasing burden of providing services to those unable to pay.

MEDICARE CUTS

The magnitude of recent Medicare hospital payment reductions is staggering. Substantial cuts in Medicare Part A expenditures were included in the Omnibus Reconciliation Acts for Fiscal Years 1987, 1988, and 1989. Congressionally mandated Medicare reductions comprised 36 percent of the savings in the Fiscal Year 1988 budget, even though Medicare accounts for only nine percent of federal outlays.

Increases in the hospital marketbasket (an inflation index of purchased goods and services) has risen by more than 28 percent since 1983, yet Medicare DRG payment rates have been increased by only 14.9 percent. This outcome is in stark contrast to the commitment of the prospective payment system (PPS) legislation to provide for annual inflation adjustments in hospital payments.

It is important to recognize that, while Medicare outlays in total are increasing, the hospital component of these expenditures is not the driving force. In the period 1985-89, Medicare inpatient payments on a per beneficiary basis declined in real terms at an annual rate of -0.6 percent. In fact, in the period 1980-88 Medicare spending for hospital services declined from 73 percent to 65 percent of total program spending. As noted earlier, Medicare payments for hospital services are increasing much less than the rate of increase in the hospital marketbasket, and far less than the 13.5 percent growth rate in the rest of Medicare. The three charts at the conclusion of this paper clearly illustrate these changes.

Payment reductions of this magnitude are unprecedented. More importantly, they have not occurred without consequences to all who depend on hospital services. Last year a record 81 hospitals closed, and over 400 hospitals have closed since 1982. Nearly 50,000 hospital beds have been eliminated since the advent of PPS. This year more than 50 percent of hospitals will actually lose money on the care they provide for Medicare patients, according to projections released by the Prospective Payment Assessment Commission (ProPAC). It is further estimated that the average hospital Medicare operating margin in FY 99 will be -11.5 percent should the Administration's budget proposals be enacted (Source: Consolidated Consulting Group).

MEDICAID REDUCTIONS

Although federal budget policies have recently avoided major reductions in the Medicaid program, in most states Medicaid hospital payments remain woefully inadequate. In 1984, according to a report of the House Committee on Energy and Commerce, Medicaid recipients used 11.6 percent of total days of inpatient hospital care and 12.7 percent of outpatient visits while the program accounted for only 8.8 percent of total hospital revenues.

Comparing average Medicaid per diem hospital payments with average hospital per diem costs in 1985, the report notes that 32 states pay rates less than average costs. Moreover, many states have imposed limitations on services for Medicaid recipients that affect the number of days or the types of admissions for which they will pay. In the period since 1980, Medicaid spending for hospital care has grown more slowly than the rest of Medicaid, increasing on average 8.6 percent per year, while total Medicaid spending has increased 10.1 percent. In sum, for most hospitals Medicaid payments are inadequate and likely to be getting worse.

COMPETITION IN THE PRIVATE MARKET

Private purchasers of health care services are aggressively seeking the lowest price, and consequently many hospitals have been forced to accept deep discounts against their customary rates. These discounts reflect the unwillingness of private purchasers to continue what they perceive as cost shifting and their subsidization of inadequate payment by Medicare and Medicaid and to cover the costs of care for unsponsored patients. By paying rates that reflect only the experience and cost of their own insured population, private purchasers have eroded hospitals' principal means of financing the care of patients with inadequate or no payment resources.

BURDEN OF UNCOMPENSATED CARE

Between 25 and 37 million Americans under the age of 65 lack health insurance. With the growth in the number of uninsured occurring at the same time as changes in payment strategies of private insurers and the federal government, it has become increasingly difficult for hospitals to shift the costs of treating the uninsured. Uncompensated hospital care nationally cost hospitals over $8.4 billion in 1986, six percent of total hospital costs. This figure understates hospitals' true burden because it does not include lower than cost reimbursement from the Medicare or Medicaid programs.

Our not-for-profit multi-hospital systems remain committed to providing needed health care services to the poor. Although our commitment remains intact, the dwindling resources available to hospitals to finance this care cause us concern.

OTHER STRESSES ON OUR NATION'S HOSPITALS

These national statistics on Medicare payment policies do not tell the full story of the impact of this sustained effort to cut hospital payments. Hospitals among our member systems have significantly reduced utilization while the full-time staff to patient ratio has increased, reflecting the growing severity of illness among current inpatients.

Institutions have also been forced to delay or abandon plans to modernize their facilities or to acquire new diagnostic and therapeutic modalities which offer advancements in patient care. The overall effects of these decisions are difficult to measure, but it is clear that compromises such as these will erode the quality and accessibility of hospital services to all our patients.

Two other payment policies have had a negative effect on hospitals: capital cost reimbursement and outpatient payments. For the past three years, payments for capital costs of hospitals have been arbitrarily reduced as a part of deficit reduction legislation. Currently capital payments are reduced by 15 percent across the board, and the Administration has proposed to increase the cut to 25 percent in FFY 1990. While some mistakenly believe these cuts will constrain future hospital capital investment, the reality is that these reductions largely impact fixed capital costs incurred in good faith by hospitals in the past. Reductions in these payments simply require hospitals to make further reductions in their operating budgets in order to service their overall financial obligations. In short, the effect of Medicare capital payment cuts is not confined to the hospital's capital budget, and reduces funds available to care for patients.

Another area that has been the target of repeated budget cutting is Medicare outpatient payments. Despite the intention under PPS to encourage hospitals to move services into the most economical setting, recent policy changes have been adopted that severely cut payments to hospitals for services regardless of where they are provided. These policies seem inconsistent with the stated intention of the incentives enacted under PPS. Furthermore, complex and fragmented billing procedures for outpatient services have been imposed on hospitals which frequently put them at a competitive disadvantage with freestanding ambulatory centers. Further reductions in these payments would only penalize hospitals for doing what was expected of them when the PPS legislation was enacted.

CONCLUSION

The AmHS Institute recognizes the magnitude of the economic and budgetary problems confronting the Congress and the Administration. However, it is vitally important that all policymakers recognize the changes which have already been enacted in Medicare hospital payment policy. Hospital payments have declined as a percentage of Medicare spending after decades of growth. We believe the hospital system has reached the limits of its ability to respond with further efficiencies without compromising the quality of patient care.

We, therefore, urge you to reject further cuts in hospital payments under Medicare in the FY 1990 budget.

TABLE 1
National Health Spending, Hospital Spending, and the Gross National Product, Selected Years, 1965 - 1987

	Health Spending as % of GNP	Hospital Spending as % of Health Spending	Hospital Spending as % of GNP
1965	5.9 %	33.4 %	2.0 %
1970	7.4 %	37.3 %	2.8 %
1980	9.1 %	41.0 %	3.7 %
1981	9.4 %	41.5 %	3.9 %
1982	10.2 %	41.8 %	4.3 %
1983	10.5 %	41.1 %	4.3 %
1984	10.3 %	40.2 %	4.2 %
1985	10.4 %	39.8 %	4.2 %
1986	10.7 %	39.2 %	4.2 %
1987	11.1 %	38.9 %	4.3 %

Source: Health Care Financing Administration.

TABLE 2
Medicare Inpatient and Outpatient Hospital Spending, Selected Years, 1975 to 1989 (estimated) (In Millions of Dollars)

Spending	Total Medicare Benefits	Inpat. Hospital	Hospital Outpat. Hospital	Total Hospital	Other Medicare Benefits
1975	$14,118	$ 9,947	$ 530	$10,477	$ 3,641
1980	33,934	22,864	1,847	24,711	9,223
1985	68,576	44,075	3,903	47,978	20,598
1986	74,036	46,042	4,925	50,967	23,069
1987	79,736	46,697	5,793	52,490	27,246
1988e	85,584	48,250	6,795	55,045	30,539
1989e	93,329	51,083	8,097	59,180	34,149
Ave. Ann. % Increase					
1975 - 85	17.1 %	16.1 %	22.1 %	16.4 %	18.9 %
1985 - 89	8.0 %	3.8 %	20.0 %	5.4 %	13.5 %

Source: U.S. House Committee on Ways and Means. Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means. 1988 Edition.

TABLE 1

Annual Growth Rate in Medicare Inpatient Hospital Costs Per Enrollee, In Constant (1986) Dollars, Selected Years, 1970 - 1986

1970 - 1980 Average	2.3 %
1981	2.4 %
1982	0.5 %
1983	0.1 %
1984	-0.7 %
1985	-0.4 %
1986	-3.3 %
1981 - 1986 Average	-0.2 %

Source: U.S. General Accounting Office. Medicare and Medicaid; Updated Effects of Recent Legislation on Program and Beneficiary Costs, July, 1988.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Administration's FY-1990 Budget Proposal to Reduce the Indirect Medical Education Adjustment

Hearing on Medicare Budget
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Submitted to the
Senate Committee on Budget

aamc

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The Administration's FY 1990 budget proposal for the Medicare program is currently being debated in Congress. This analysis is submitted by the Association of American Medical Colleges (AAMC) with specific reference to the "indirect medical education (IME) adjustment," a payment made to teaching hospitals under the Medicare Prospective Payment System (PPS).

The Administration's budget proposes a cut in the IME adjustment from the current 7.7 percent to 4.05 percent. The AAMC, which represents the nation's 127 medical schools, over 435 major teaching hospitals and 83 academic medical societies, firmly opposes this substantial reduction.

The "indirect medical education (IME) adjustment" is an integral, yet misunderstood, component of the Medicare PPS. While its title has led many to believe that this adjustment to the Diagnosis Related Group (DRG) payments is to compensate for education and related program costs, its purpose is much broader and has been specifically identified as follows:

> This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (Senate Finance Committee Report, Number 98-23, March 11, 1983).

The AAMC is greatly concerned that recent analyses have led some to conclude that the indirect medical education adjustment can be cut substantially without undermining the financial viability of the nation's teaching hospitals. The level at which the IME adjustment is set will have a profound operational effect on teaching hospitals.

In order to inform and assist you in your consideration of the appropriate level of the IME adjustment, the AAMC submits the attached analysis of PPS and total margins for a group of forty-five academic medical center hospitals that are members of the AAMC's Council of Teaching Hospitals (COTH).

Data and Findings

The attached four tables use the financial data of forty-five hospitals that responded by February 15 to the FY 1988 COTH Survey of Academic Medical Center Hospitals' Financial and General Operating Data. The survey is mailed annually to 121 academic medical center hospitals. These data are collected from the hospital's most recently completed fiscal year, which for most of the institutions, ended in June or September 1988. PPS data reported in these tables are from the hospitals' "as submitted" Medicare cost reports. Operating and total margin data are reported from audited financial statements.

Because AAMC policy prohibits the release of hospital-specific data without permission of the hospital chief executive, we have masked the identity of individual institutions in all tables. However, an alphabetical list of the responding hospitals is attached as Appendix A.

For this analysis the PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, indirect medical education and outlier payments) less Medicare inpatient operating costs, divided by PPS revenue. This definition excludes Medicare revenue and costs associated with capital, direct medical education, PPS exempt patient care units and some other categories. Because payments for these cost components are made on a cost or less-than-cost reimbursement basis, the margin for these items cannot be positive. Therefore, overall margins for Medicare inpatient beneficiaries will be less than the PPS margins shown in this analysis.

Table 1 shows that average PPS margins for this group of hospitals dropped dramatically in FY 1988 to 5.6 percent. Of 39 hospitals reporting PPS margin data in both 1987 and 1988, 29 (74 percent) had lower margins in 1988. While only one hospital had a negative PPS margin in 1986, by 1988 twelve hospitals reported PPS margins less than zero.

Table 2 uses 1988 data to demonstrate the impact of the various types of PPS payments on hospital margins and the effect of cutting the IME adjustment in half. This period represents the first year these hospitals received a per case DRG payment based 100 percent on nationally-based PPS payments. A striking finding in Table 2 is the significant contribution of the payment adjustments (IME and disproportionate share) to reducing the large losses that would result if payment were limited to the DRG rate plus outliers.

The far right column of Table 2 shows the average PPS margin would have been a negative 5 percent in 1988, if the IME adjustment had been 4.05 percent, rather than the positive 5.6 percent PPS margin in Table 1. During the reporting period, hospitals received an IME payment at the 8.1 percent level; therefore, a reduction of the payment by one-half pays hospitals at the 4.05 percent level, assuming no change in the FY 1988 intern and resident to bed ratio.

Table 3 shows that for this group of hospitals the IME and disproportionate share payments constitute a significant portion of their total PPS payments. About one-fourth of these hospitals' total PPS payments can be attributed to these adjustments. However, a high percentage of these payments relative to the total payment does not necessarily guarantee a large positive margin.

Table 4 shows both operating and total hospital margins for all payers for three years. As with PPS margins, there is a definite downward trend in both margins. The average operating margin was negative in 1988. Total margins, which include gifts and endowment income, were cut by almost half during the period, falling from 6.3 percent in 1986 to 3.6 percent in 1988.

Discussion

In the initial years of PPS, major teaching hospitals' PPS margins were high relative to some other types of hospitals. The determination of the hospital-specific DRG price was a major contributor to these profits. In the early years of PPS, when DRG prices were based 75 percent on the hospital-specific price component, major teaching hospitals earned their largest margins. Since the IME adjustment was applied only to the 25 percent federal portion of the rate, it made a relatively small contribution to teaching hospitals' PPS margins. Today, with DRG prices based 100 percent on the national rate and payments for capital and direct medical education costs being reduced, teaching hospital margins are generally low and the adjustments, including the IME adjustment, are increasingly important to teaching hospitals. It should also be noted that the IME adjustment has already been cut thirty percent from its original level of 11.59 percent.

Teaching hospitals will be unable to withstand further reductions in the IME payment, particularly since margins on both Medicare and non-Medicare patients are dropping dramatically. The IME payment is an important equity factor in the Medicare prospective payment system, compensating teaching hospitals for the severity of their patients' illnesses, the scope of services provided and the impact of teaching hospital programs on hospital operating costs. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must fulfill their unique educational and service missions.

A major and/or sudden reduction in the IME adjustment would constitute a severe economic hardship for teaching hospitals and hinder their future capability to support adverse patient selection within DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. As indicated earlier, the AAMC firmly opposes any reduction in IME payments. You are urged to consider carefully the impact of a reduction in the indirect medical education adjustment on teaching hospitals.

Attachment

TABLE 1: PPS MARGINS IN SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986-FY 1988 RANKED BY FY 1988 PPS MARGIN

HOSPITAL	PPS MARGINS FY 86	 FY 87	 FY 88
A	25.20%	20.27%	30.03%
B	19.26%	12.42%	28.66%
C	28.15%	26.91%	27.84%
D	36.04%	11.40%	25.88%
E	32.71%	33.72%	21.77%
F	26.22%	21.31%	21.25%
G	2.11%	3.54%	20.19%
H	7.09%	12.37%	18.58%
I	22.27%	15.39%	16.48%
J	34.98%	20.17%	16.46%
K	N.A.	N.A.	16.19%
L	20.74%	19.50%	15.22%
M	23.68%	18.66%	12.53%
N	N.A.	N.A.	11.61%
O	N.A.	N.A.	10.78%
P	14.27%	16.07%	10.78%
Q	20.72%	16.78%	10.66%
R	39.17%	31.25%	9.89%
S	24.06%	15.93%	9.69%
T	N.A.	N.A.	9.63%
U	25.30%	3.50%	9.11%
V	8.52%	-22.79%	6.75%
W	23.40%	21.39%	5.05%
X	19.35%	12.07%	3.88%
Y	14.38%	13.82%	3.23%
Z	20.33%	12.86%	2.76%
AA	20.61%	19.21%	2.51%
BB	13.82%	18.05%	2.48%
CC	23.06%	15.55%	2.42%
DD	25.54%	14.02%	1.80%
EE	24.74%	14.81%	1.62%
FF	8.60%	-1.33%	1.24%
GG	15.92%	8.03%	0.09%
HH	16.74%	10.13%	-0.59%
II	10.07%	7.17%	-1.39%
JJ	24.68%	10.02%	-3.37%
KK	20.93%	23.23%	-3.47%
LL	15.48%	N.A.	-3.93%
MM	18.80%	15.21%	-4.94%
NN	15.02%	5.04%	-8.20%
OO	N.A.	N.A.	-8.76%
PP	-0.16%	1.73%	-9.10%
QQ	14.94%	9.50%	-14.08%
RR	14.65%	0.66%	-14.57%
SS	7.06%	-4.76%	-20.66%
MEDIAN	20.47%	14.02%	5.06%
AVERAGE (WEIGHTED)	20.01%	14.97%	5.59%

PPS MARGIN= PPS REVENUE (WHERE PPS REVENUE= DRG PAYMENT, DISP. SHARE, INDIRECT MED. ED. AND OUTLIER PAYMENTS) LESS MEDICARE INPATIENT OPERATING COSTS, DIVIDED BY PPS REVENUE.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 2: PPS MARGINS FOR SELECTED ACADEMIC MEDICAL CENTER HOSPITALS RANKED BY PAYMENT WITH OUTLIERS, DSH, AND 1/2 IME: FY 1988

HOSPITAL	DRG PAYMT LESS OPER COSTS	PAYMENT WITH OUTLIERS ONLY	PAYMENT WITH OUTLIERS & DSH	PAYMENT WITH OUTLIERS & DSH & FULL IME	PAYMENT WITH OUTLIERS & DSH & 1/2 IME
B	0.00%	3.87%	15.27%	28.66%	22.54%
C	-4.67%	-0.22%	9.84%	27.84%	19.84%
A	-6.67%	-3.10%	5.40%	30.03%	19.55%
F	-7.40%	0.59%	5.62%	21.25%	14.14%
G	-5.70%	-0.48%	1.59%	20.19%	11.86%
D	-26.14%	-21.07%	-8.85%	25.88%	11.81%
E	-19.20%	-12.84%	-2.54%	21.77%	11.21%
H	-17.70%	-11.86%	0.31%	18.58%	10.37%
L	-20.46%	-16.05%	-3.30%	15.22%	6.87%
J	-35.41%	-23.11%	-9.32%	16.46%	5.29%
I	-19.32%	-16.59%	-9.51%	16.48%	5.24%
K	-29.13%	-20.75%	-10.63%	16.19%	4.63%
N	-18.48%	-10.84%	-4.10%	11.61%	4.39%
S	-30.71%	-16.13%	-7.35%	9.69%	1.90%
P	-19.88%	-14.79%	-10.10%	10.78%	1.43%
M	-25.46%	-20.38%	-14.11%	12.53%	0.97%
R	-15.77%	-11.59%	-11.59%	9.89%	0.30%
O	-33.50%	-26.11%	-13.33%	10.78%	0.16%
Q	-32.41%	-22.68%	-14.80%	10.66%	-0.48%
U	-35.35%	-26.12%	-14.48%	9.11%	-1.33%
T	-26.37%	-21.59%	-17.38%	9.63%	-2.12%
Y	-40.21%	-30.30%	-10.13%	3.23%	-3.02%
V	-45.00%	-30.40%	-21.35%	6.75%	-5.46%
BB	-31.96%	-17.30%	-17.30%	2.48%	-6.50%
W	-31.89%	-27.01%	-21.52%	5.05%	-6.60%
FF	-29.29%	-22.00%	-16.65%	1.24%	-6.96%
AA	-35.19%	-27.71%	-19.66%	2.51%	-7.44%
DD	-34.23%	-24.34%	-18.89%	1.80%	-7.56%
Z	-44.24%	-30.47%	-23.13%	2.76%	-8.66%
CC	-38.11%	-29.41%	-24.34%	2.42%	-9.35%
LL	-36.35%	-20.47%	-16.27%	-3.93%	-9.75%
EE	-41.33%	-32.30%	-25.70%	1.62%	-10.38%
JJ	-27.13%	-19.94%	-19.94%	-3.37%	-11.04%
X	-44.22%	-32.64%	-31.46%	3.88%	-11.05%
II	-49.83%	-38.24%	-25.30%	-1.39%	-12.08%
GG	-55.00%	-40.72%	-27.68%	0.09%	-12.10%
HH	-49.70%	-38.03%	-27.41%	-0.59%	-12.43%
KK	-34.13%	-27.91%	-27.91%	-3.47%	-14.40%
OO	-28.59%	-23.44%	-23.44%	-8.76%	-15.64%
RR	-34.11%	-26.78%	-19.87%	-14.57%	-17.16%
MM	-53.33%	-38.47%	-38.47%	-4.94%	-19.39%
PP	-51.41%	-42.54%	-33.55%	-9.10%	-20.09%
QQ	-42.18%	-34.23%	-34.23%	-14.08%	-23.34%
NN	-62.86%	-51.13%	-47.02%	-8.20%	-24.66%
SS	-61.95%	-50.60%	-44.30%	-20.66%	-31.42%
MEDIAN	-32.41%	-23.11%	-16.65%	5.05%	-5.46%
AVERAGE (WEIGHTED)	-33.22%	-24.38%	-18.15%	5.59%	-4.95%

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 3: DISPROPORTIONATE SHARE AND INDIRECT MEDICAL EDUCATION ADJUSTMENTS AS PERCENTAGES OF TOTAL PPS PAYMENTS RANKED BY FY 1988 PPS MARGIN

HOSPITAL	DSH AS OF TOTAL PPS PAYMT	IME AS % OF TOTAL PPS PAYMT	DSH & IME AS % OF TOTAL PPS PAYMT	FY 88 PPS MARGIN	FY 88 IRB RATIO
A	6.10%	26.04%	32.13%	30.03%	0.6506
B	9.99%	15.80%	25.79%	28.66%	0.5000
C	8.03%	19.96%	27.99%	27.84%	0.5775
D	6.87%	31.90%	38.78%	25.88%	0.7070
E	6.89%	23.78%	30.67%	21.77%	0.7653
F	4.22%	16.56%	20.78%	21.25%	0.5468
G	1.68%	18.90%	20.57%	20.19%	0.4736
H	8.89%	18.33%	27.21%	18.58%	0.4449
I	4.63%	23.73%	28.36%	16.48%	0.7018
J	8.56%	23.58%	32.14%	16.46%	0.5978
K	6.35%	24.24%	30.59%	16.19%	0.7600
L	9.02%	17.92%	26.94%	15.22%	0.5195
M	4.00%	23.34%	27.34%	12.53%	0.8091
N	5.16%	15.09%	20.25%	11.61%	0.5000
O	7.98%	21.27%	29.26%	10.78%	0.5413
P	3.31%	18.97%	22.27%	10.78%	0.4853
Q	5.00%	22.18%	27.18%	10.66%	0.6978
R	N.A.	19.25%	19.25%	9.89%	0.4805
S	6.36%	15.87%	22.23%	9.69%	0.3878
T	2.67%	23.01%	25.68%	9.63%	0.6493
U	7.33%	20.61%	27.94%	9.11%	0.6925
V	5.34%	23.16%	28.49%	6.75%	0.5490
W	3.37%	21.87%	25.24%	5.05%	0.5735
X	0.65%	26.89%	27.53%	3.88%	0.5631
Y	13.60%	12.13%	25.73%	3.23%	0.4451
Z	4.44%	21.03%	25.47%	2.76%	0.4308
AA	5.13%	18.53%	23.67%	2.51%	0.5400
BB	N.A.	16.86%	16.86%	2.48%	0.4278
CC	3.07%	21.53%	24.60%	2.42%	0.5612
DD	3.62%	17.40%	21.02%	1.80%	0.4502
EE	3.90%	21.73%	25.64%	1.62%	0.6501
FF	3.72%	15.34%	19.05%	1.24%	0.4073
GG	7.25%	21.75%	29.00%	0.09%	0.7506
HH	6.07%	21.05%	27.12%	-0.59%	0.5851
II	7.57%	19.09%	26.66%	-1.39%	0.6172
JJ	0.00%	13.81%	13.81%	-3.37%	0.3078
KK	0.00%	19.11%	19.11%	-3.47%	0.4767
LL	3.11%	10.62%	13.73%	-3.93%	0.3462
MM	0.00%	24.22%	24.22%	-4.94%	0.4308
NN	2.00%	26.40%	28.40%	-8.20%	0.6366
OO	N.A.	11.90%	11.90%	-8.76%	0.3810
PP	5.15%	18.31%	23.46%	-9.10%	0.5397
QQ	N.A.	15.01%	15.01%	-14.08%	0.3251
RR	5.21%	4.42%	9.63%	-14.57%	0.1014
SS	3.50%	16.38%	19.88%	-20.66%	0.4685
MEDIAN	5.13%	19.25%	25.64%	5.05%	0.5400
AVERAGE (WEIGHTED)	4.00%	20.10%	24.10%	5.59%	N.A.

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

TABLE 4: OPERATING AND TOTAL MARGINS FOR SELECTED ACADEMIC MEDICAL CENTER HOSPITALS: FY 1986-FY 1988

	OPERATING MARGINS			TOTAL MARGINS		
HOSPITAL	FY 86	FY 87	FY 88	FY 86	FY 87	FY 88
A	7.47%	-4.05%	-4.16%	11.77%	0.46%	0.77%
B	11.58%	6.10%	-10.99%	13.41%	7.86%	9.87%
C	19.85%	18.96%	14.45%	19.85%	19.51%	14.83%
D	5.92%	-0.48%	0.01%	6.87%	0.52%	1.08%
E	1.57%	3.39%	1.51%	2.57%	4.48%	1.09%
F	2.90%	10.05%	5.49%	3.08%	8.42%	5.92%
G	3.34%	5.93%	4.03%	3.34%	5.93%	4.03%
H	9.29%	8.37%	9.37%	8.37%	9.29%	9.37%
I	6.90%	5.17%	3.99%	6.99%	5.34%	3.79%
J	-40.36%	-34.84%	-43.40%	-1.19%	-0.81%	-0.77%
K	N.A.	N.A.	-88.48%	N.A.	N.A.	-2.03%
L	-7.86%	-11.98%	-13.05%	-7.86%	-11.98%	-13.05%
M	5.00%	5.34%	7.42%	5.01%	5.32%	7.89%
N	N.A.	N.A.	0.27%	N.A.	N.A.	1.52%
O	N.A.	N.A.	0.41%	N.A.	N.A.	4.77%
P	6.36%	5.87%	2.03%	6.16%	5.64%	3.31%
Q	8.02%	1.91%	-0.66%	8.43%	6.39%	3.52%
R	10.92%	10.69%	10.00%	15.48%	13.99%	12.56%
S	10.73%	4.58%	3.64%	10.73%	4.58%	7.03%
T	N.A.	N.A.	3.14%	N.A.	N.A.	8.51%
U	0.64%	-0.79%	-5.79%	9.49%	0.55%	1.79%
V	14.00%	8.41%	7.72%	16.55%	11.38%	10.21%
W	2.47%	0.15%	-1.47%	6.63%	4.37%	2.30%
X	2.26%	0.84%	0.89%	5.33%	3.95%	3.65%
Y	-0.63%	0.13%	-0.29%	-0.64%	-0.13%	-0.47%
Z	2.59%	-0.85%	-4.76%	4.84%	1.85%	-2.13%
AA	7.45%	7.47%	6.73%	8.66%	8.88%	8.78%
BB	-2.31%	-1.71%	-3.35%	0.36%	0.01%	-0.46%
CC	7.66%	2.64%	0.65%	12.72%	4.62%	2.89%
DD	3.72%	1.55%	1.22%	5.31%	3.60%	3.47%
EE	8.67%	5.61%	5.43%	9.18%	10.09%	6.06%
FF	7.77%	2.24%	2.71%	10.55%	2.55%	3.04%
GG	3.61%	0.47%	1.81%	5.35%	1.87%	2.38%
HH	-13.23%	-17.58%	-16.95%	1.47%	2.00%	1.16%
II	5.06%	3.14%	3.36%	5.06%	3.14%	3.36%
JJ	10.40%	6.26%	1.96%	10.63%	6.96%	2.59%
KK	2.80%	8.80%	5.70%	5.44%	8.06%	8.15%
LL	0.89%	3.53%	2.24%	1.82%	4.47%	3.05%
MM	0.81%	0.24%	-1.10%	0.98%	0.75%	-0.42%
NN	-4.72%	-6.05%	2.01%	-2.03%	-4.17%	3.45%
OO	N.A.	N.A.	-24.17%	N.A.	N.A.	1.57%
PP	3.18%	0.31%	3.82%	3.18%	0.31%	3.82%
QQ	7.03%	8.32%	1.64%	8.33%	9.37%	2.44%
RR	11.67%	10.47%	4.34%	13.54%	19.62%	6.12%
SS	6.83%	4.70%	2.15%	7.53%	5.68%	4.24%
MEDIAN	5.30%	3.27%	1.81%	6.40%	4.53%	3.36%
AVERAGE (WEIGHTED)	2.65%	1.07%	-1.74%	5.26%	4.69%	3.55%

SOURCE: ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FY 1987 AND FY 1988 COTH ACADEMIC MEDICAL CENTER HOSPITAL SURVEY.

ACADEMIC MEDICAL CENTER HOSPITALS PROVIDING DATA
FY 1986-FY 1988

CRAWFORD LONG
DUKE UNIVERSITY
EMORY UNIVERSITY HOSPITAL
GEORGETOWN
HAHNEMANN
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
INDIANA
KENTUCKY
LA COUNTY-USC MEDICAL CENTER
LOUISIANA STATE UNIVERSITY
MASSACHUSETTS GENERAL
MEDICAL COLLEGE OF GEORGIA
MEDICAL COLLEGE OF OHIO
MEDICAL COLLEGE OF VIRGINIA
NORTH CAROLINA BAPTIST
NORTH CAROLINA MEMORIAL
NORTHWESTERN MEMORIAL
OREGON HEALTH SCIENCES
REGIONAL MEDICAL CENTER AT MEMPHIS
SAN FRANCISCO GENERAL
SHANDS (UNIVERSITY OF FLORIDA)
ST LOUIS UNIVERSITY
TEMPLE
UNIVERSITY OF CALIFORNIA, DAVIS
UNIVERSITY OF CALIFORNIA, IRVINE
UNIVERSITY OF CALIFORNIA, LOS ANGELES
UNIVERSITY OF CALIFORNIA, SAN DIEGO
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
UNIVERSITY OF CINCINNATI
UNIVERSITY HOSPITALS OF CLEVELAND
UNIVERSITY HOSPITAL (COLORADO)
UNIVERSITY OF KANSAS
UNIVERSITY OF MARYLAND
UNIVERSITY OF MICHIGAN
UNIVERSITY OF MISSISSIPPI
UNIVERSITY OF NEBRASKA
UNIVERSITY OF NEW MEXICO
UNIVERSITY OF SOUTH ALABAMA
UNIVERSITY OF UTAH
UNIVERSITY OF VIRGINIA
UNIVERSITY OF WASHINGTON
UNIVERSITY OF WISCONSIN
VANDERBILT
VERMONT
YALE-NEW HAVEN

NOTE: HOSPITALS ARE LISTED ABOVE IN ALPHABETICAL ORDER. HOSPITAL ORDER HAS BEEN CHANGED IN THE ACCOMPANYING TABLES.

HOSPITALS IN WAIVERED STATES PROVIDE PPS DATA AS IF THEY WERE BEING PAID UNDER FEDERAL PAYMENT RULES.

WRITTEN QUESTIONS FROM SENATOR SASSER TO SECRETARY SULLIVAN AND THE RESPONSES

WELFARE REFORM

Question 1. Does the Bush Administration intend to provide full funding to implement the Welfare Reform legislation?

Answer. Yes. The FY 1990 budget request includes sufficient funding to implement the provisions of the recently enacted Family Support Act of 1988. It is our understanding that CBO estimates for 1990 are consistent with our budget request for the Family Support Act of 1988.

Question 2. Does the Bush Administration consider JOBS to be a discretionary program in spite of explicit language in the legislation that funds JOBS as a capped entitlement? Will the Administration propose new language to change current law?

Answer. Mr. Richard Darman, Director of OMB, states that he considers JOBS to be a capped entitlement. Proposed changes to the cap were contained in the Reagan budget submitted on January 9. Using the Reagan budget as a starting point for negotiations, JOBS and WIN are funded at the best current estimate of FY 1990 program costs. If the estimate were insufficient to cover program costs, a supplemental would be needed.

Question 3. Three states—California, Massachusetts, and New Jersey—are counting on their share of the $800 million capped entitlement to begin implementation of JOBS in 1990. If only $350 million is appropriated, the current funding formula would not allocate sufficient funds to these states to pay for their programs. Does the Administration propose some kind of reallocation procedure that would allow these states to receive the full entitled amount?

Answer. The request for $350 million is based on Administration and CBO estimates of state spending on JOBS including the level of funds needed by these three states. No reallocation should therefore be necessary to allow these states to move forward in implementing JOBS.

AFDC ADMINISTRATIVE FUNDS

Question 4. If AFDC administrative funds are frozen at 1989 levels (or are reduced below current services estimates), what would be the expected impact on states in operating these programs?

Answer. As a result of negotiations with Congress, AFDC administrative costs may be frozen at 1989 levels, and states would then be expected to share a greater portion of the operating costs of these programs. States can increase management efficiency and productivity to respond to Federal levels of funding without affecting program operations or benefit levels.

Question 5. Isn't it true that many states will not be able to offset the loss in federal support for operating these programs and would thus resort to reducing services or lowering benefits.

Answer. The Administration does not expect that states would respond by reducing services or lowering benefits. Savings can be achieved by increasing administrative efficiency, including management and productivity improvements.

Question 6. Freezing administrative funding for AFDC and reducing it below current services levels would require a change in the matching rate in current law. Does the Bush Administration intend to propose specific legislative changes in these programs?

Answer. The Bush Budget includes AFDC State and local administrative funding in the residual category. The Bush Budget does not propose specific budget authority or outlay amounts for spending which falls into this residual category. Rather, the Bush Budget proposes spending $136 billion on all programs which would be funded from this amount, with the details of that spending to be negotiated with Congress. Specific legislation will be sent to the Congress as appropriate. The Reagan Budget proposal may serve as a useful starting point for these discussions with Congress.

Question 7. Reagan's 1990 budget also proposed reducing federal expenditures for administrative costs for AFDC. Does the Bush Administration endorse Reagan's proposals to change federal reimbursement of state administrative costs for these programs? Will you be making specific legislative proposals?

Answer. The Bush Budget includes AFDC State and local administrative funding in the residual category. The Bush Budget does not propose specific budget authority or outlay amounts for spending which falls into this residual category. Rather, the Bush Budget proposes spending $136 billion on all programs which would be funded from this amount, with the details of that spending to be negotiated with Congress. Specific legislation will be sent to the Congress as appropriate. The Reagan Budget proposal may serve as a useful starting point for these discussions with Congress.

REFUGEE ASSISTANCE

Question 8. What is the Bush Administration's position on funding for refugee assistance? Do you support the large reductions proposed by the Reagan Administration?

Answer. In FY 1990, the Administration's proposed 1990 budget for refugee resettlement totals $242 million. This funding level supports 84,000 refugees (the ceiling set by Congress and the Administration last September) for a 15/12 month period of reimbursement. At this level, the Federal government subsidizes the States' share of cash and medical assistance for categorically eligible refugees (i.e., those receiving AFDC, Medicaid or SSI) for roughly a 15 month period. The federal funding level for noncategorical refugees (those who are not eligible for AFDC and Medicaid) would be 12 months.

Question 9. If so, how do you expect the states to continue the current level of support for refugees if they are being forced to absorb a significant shortfall of federal assistance?

Answer. The rationale for limiting subsidies to 15 months continues to be to provide States with a stronger incentive to move quickly to help refugees to become independent and self-sufficient as soon after coming into this country as possible. Refugees who remain dependent after the end of the first 15 months will continue, if eligible, to receive assistance, but States will then be responsible for absorbing their normal share of the cost of such assistance.

WRITTEN QUESTIONS FROM SENATOR EXON TO SECRETARY SULLIVAN AND THE RESPONSES

SCIENTIFIC RESEARCH FUNDS

Question 1. As you may know, I introduced legislation last year aimed at the National Science Foundation to request a more equitable distribution of scientific research funds to smaller states. I am also concerned that in medical research funds, there is a sort of "old boy" network. Peer reviewers are from those institutions which already get significant federal assistance and those who already get assistance continue to get assistance. As you know, there is a wealth of talent and high quality research on going in many of America's smaller schools. Do you have any recommendations which will address this problem and make research funds available to qualify projects in smaller states?

Answer. While there are many perceptions of inequitable distributions of scientific research funds to smaller states, these were examined and reported two years ago in a GAO report, "University Funding/Patterns of Distribution of Federal Research Funds to Universities" (GAO/RCED-87-67BR). Principal findings from those analyses were:

". . . from 1967 to 1984, the composition of the top 100 (funded academic) institutions has changed, with 19 institutions moving into the top 100.

". . . when federal research funds are examined by field of science, states and institutions that rank below the top in total federal research funds may become among the top in a particular field of science.

"Federal research and development funding to universities and colleges by state positively correlates to varying degrees with the demographic and socieconomic factors of population size, . . . employees, scientists and engineers, number of Ph.D's granted in science and engineering, and federal research and development funds to other than universities and colleges.

"NIH and NSF peer review participants and the number of NIH and NSF awards are less concentrated geographically than NIH and NSF research funds.

This report demonstrates that factors other than an "old boy" network and similar biases operate to concentrate research funds in certain states and institutions, and also that concentrations of research funds are not as pervasive as imagined.

At the NIH, while the search for maximal benefits from investments of R&D funds results in large portions of research

HELP FOR PREGNANT MOTHERS

Question 2. As you may know, I share President Bush's antiabortion views and have a consistent pro-life voting record. I applaud your full endorsement of the President's position on this difficult issue.

I am concerned that the litmus test on the Right to Life issue begins and ends on the narrow point of whether abortion is legal or illegal. If the objective is to reduce and someday eliminate abortion on demand, I believe that there are factors other than legality and that needs to be examined, after all, there were abortions when the procedure was illegal.

Should we not also focus on some of the economic factors which work against many young women who chose life over abortion? In this regard, is it not unwise to cut programs such as the Women, Infant and Children (WIC) Feeding program as the President's Budget recommends? Do you have any recommendations regarding employment, education and health initiatives especially for young women, which could effectively reduce abortions, even in the current legal framework?

Answer. One program administratered by the Public Health Service, the Adolescent Family Life Research and Demonstration program (Title XX of the Public Health Service Act) was established in 1981 specifically designed as an alternative to abortion. AFL provides health, educational and social support services for pregnant and parenting teens, including services to promote adoption as a positive alternative. AFL also supports educational services designed to encourage adolescents to postpone sexual activity. The President's budget for 1990 includes continued support at a level of $10 million for the AFL program. The AFL program is the only Federal program focused exclusively on the problems of teenage sexual behavior and teenage pregnancy. Currently, AFL supports 66 multi-year care and prevention projects to demonstrate new and innovative approaches to the delivery of health, education and social support services to pregnant and parenting teens, as well as approaches to prevent adolescents from becoming sexually active. AFL also supports 14 research projects on teen sexual behavior, adoption, family communication, and adolescent childbearing.

In addition, the Public Health Service administers the Title X national Family planning program which provides free (or low cost) contraceptive methods and services to approximately 4.3 million low income women annually in over 4,000 clinic sites nationwide. About one-third are adolescents. Family planning services for sexually active persons are intended to assist them in planning the spacing and number of children. Quality family planning services should have the effect of reducing the incidence of unplanned pregnancies and abortion. The President's budget for 1990 proposes that the current program of categorical grants become a State administered program of family planning grants which will enable States to better serve local family planning needs, and reducing the incidence of abortion from unplanned or unwanted pregnancies.

NURSING SHORTAGE

Question 3. In the midst of a nation-wide nursing shortage, there are nursing schools across this country which are underutilized. Rather than go overseas for nursing talent, as some hosptials and health organizations do now, would it not be better to go into some of American's pockets of high employment and offer incentives and scholarships to educate young men and women for this rewarding and increasingly well-paid profession?

Answer. When the enrollments in nursing schools declined, schools developed innovative recruitment programs which included targeting recruitment efforts toward nontraditional students. Many of the nursing schools are carrying out these activities as well as offering innovative educational programs which promote career mobility or recruit individuals with degrees in other fields into nursing. All of these are effective ways of recruiting students into nursing.

The Department's nursing revolving loan funds will make approximately $23 million in loans to about 11,500 students. The Department of Education's Guaranteed Student Loan Program, and other loan and scholarship resources available through State and local government programs and private endowments are also available to nursing students.

WRITTEN QUESTIONS FROM SENATOR LAUTENBERG TO SECRETARY SULLIVAN AND THE RESPONSES

REFUGEE ASSISTANCE

Question 1. Are you aware that although 7,500 of the 125,000 Cubans who came to the United States in the early 1980's came *directly* to New Jersey, approximately 15,000 more have moved to New Jersey since then?

Answer. As of 1982, the Office of Refugee Resettlement estimated the number of Cuban entrants living in New Jersey at 10,500. This number includes data on initial resettlement and secondary migration provided by State department officials. In 1984–85, when Cuban entrants were allowed to apply for adjustment to permanent resident alien status, 8,850 Cubans applied in New Jersey, about 9 percent of the total Cuban population that applied for this status. We show no evidence of substantial migration since that time.

Question 2. Have you approved of this regulatory change?

Answer. We published a notice of proposed allocations for Targeted Assistance in the Federal Register in January. We are currently reviewing and considering comments that we have received concerning this proposed allocation.

Question 3. Would you agree to take a fresh look at this regulation and consider incorporating a "secondary migration?"

Answer. Data are not available on secondary migration at the county level. We have allowed for secondary migration to enter the allocation criteria indirectly in terms of the numbers of cash assistance recipients. If secondary migrants are receiving this assistance, they have been counted.

Question 4. Are you aware that the Cuban refugee population in New Jersey has a welfare dependency rate of approximately 25% compared to the national average of 50%?

Answer. New Jersey's dependency rate for refugees compares favorably with the national average. However, the rates pertain only to refugees (of all nationalities) who have arrived in the previous 24 months, not to those who arrived in 1980. The State has provided services to these entrants over the past six years and, with the benefit of those services, most have become self-sufficient.

Question 5. Do you agree that this record makes New Jersey one of the Nation's most efficient users of targeted assistance funds, and that those funds have been well spent in the State?

Answer. We do not refute that New Jersey has spent their Targeted Assistance funds well, however, we have proposed to direct Targeted Assistance dollars to those areas that have the greatest number of dependent refugees. Many other counties are experiencing a greater impact from refugee arrivals than counties in New Jersey.

Question 6. Given New Jersey's outstanding record, don't you agree that cutting off targeted assistance funds appears to punish the State for its efficiency rather than reward it?

Answer. The purpose of Targeted Assistance dollars is to place extra funds in counties that are currently experiencing heavy impact. The fact that New Jersey no longer qualifies indicates that the refugee situation in the State has improved; it does not imply that the State is being "punished."

Question 7. Are you aware that cutting off Targeted Assistance funding for this population would likely lead to an increase in unemployment and welfare dependency?

Answer. We have provided sufficient funding to allow for an orderly phaseout of New Jersey's Targeted Assistance program. We also provide funding for services to refugees and entrants through our regular social services grants.

Question 8. Will you agree to give a fresh look at the weight given to employment success rates before making a final decision on this matter?

Answer. Comments received on the proposed formula for allocating Targeted Assistance funding are being considered. Our proposed formula attempts to direct funding to the areas of greatest need, as shown by recent dependency rates and arrival trends from 1983 to the present. We are weighing the comments and some new data submitted by commenters before making a final decision.

WRITTEN QUESTIONS FROM SENATOR SANFORD TO SECRETARY SULLIVAN AND THE RESPONSES

PROSPECTIVE PAYMENT SYSTEM

Question 1. I would like to submit to you a letter sent to me from Duke Univeristy Medicial Center. I would like you and your staff to respond to the questions raised in this letter.

Answer. We share the concern that the Duke University Medical Center receive adequate payment for services to Medicare beneficiaries. However, I would like to start by noting some facts about the prospective payment system (PPS)

PPS was initially developed using 1981 costs. These costs, updated to 1984, overstated the costs hospitals faced under PPS incentives, and as a result, hospitals experienced Medicare operating margins averaging approximately 15 percent during the first 2 years of the program. In order to correct this overpayment, and because hospitals wre responding to PPS incentives by improving their productivity and efficiency, we updated the rates by amounts less than the hospital market basket increase.

As the payment system has become fully implemented, the average hospital Medicare operating margins have declined. However, we should note that overall profit margins remain higher than they were over the decade prior to implementation of PPS.

Large teaching hospitals, such as Duke University Medical Center, have generally fared well under PPS. We note that in FY 88 Duke University Medical Center made over $2 million in Medicare profits. The hospital may be projecting losses from its Medicare operations for FY 1989 (the sixth year of PPS), however, for the first 5 years of PPS Duke enjoyed significant Medicare profit margins.

Finally, it is not the intention of the Department or of HCFA to be unresponsive to or uncommunicative with hospitals. We recognize that financially viable hospitals are essential to the provision of quality care to Medicare beneficiaries.

LACK OF COMMUNICATION WITH HOSPITALS

Question 1. In speaking with hospital officials in North Carolina, a consistent and critical complaint involves the lack of clear communication between hosptials and the Health Care Financing Administration. There have been cases where reports were ordered, regulations changed, and penalties imposed with little or no warning. How would you encourage a better relationship between HCFA and hospitals across this country? How would you make HCFA more sensitive to hospital needs than has been show in the past?

Answer. It is my intention that HCFA always be responsive to questions raised by hospitals, and that the hospital industry, as well as individual hospitals, be informed of changes in regulations that affect them. Over the past 8 years there have been many changes in how hospitals are paid. Implementation of the prospective payment system has resulted in a great deal of confusion by all concerned. Throughout the period, HCFA has sought to explain the system as clearly as possible. To the extent possible, we have published proposed changes in the PPS rates in the Federal Register for public comment before issuing them in final form. However, the complexity of PPS as well as the number and frequency of legislative changes, often makes clear communication difficult.

Finally, hospitals interact principally with fiscal intermediaries with respect to Medicare payment. Because of this additional layer, and because intermediaries have their own methods for communicating with hosptials, the communications process is more complex.

Let me assure you that during my tenure as Secretary, I will make every effort to maintain open and clear lines of communication between the Medicare program and hospital.

UPDATING REIMBURSEMENT CALCUATIONS

Question 1. Another common complaint among health care providers around the country involves the procedures and data used in determining cost rates and wage indexes. The figures used are several years old (1983–1985), therefore providing extremely low rates compared to actual 1989 costs. What plans are there to update the data used to calcuate reimbursement rates to more accurately reflect actual costs?

Answer. The payments that hospitals receive are based on the standardized payment rates, the case mix index of the individual hospital, and the wage index of the area in which the hospital is located. Case mix is taken from the previous Federal fiscal year, which is the most current time period that is attainable. Standard payment rates are based on the yearly updating of 1981 hospital cost data. The update factor is calculated using the most recent hospital market basket forecast that is available. Finally, wage indexes are currently calculated on the basis of a blend of 1982 and 1984 wage surveys. The lag in wage data concerns us as well as the hospital industry, and we are taking steps to obtain more recent information. We are undertaking a wage survey at this time, but will not be able to use the results until FY 1991. We are, however, making an effort to develop a mechanism so that we can obtain accurate survey data yearly.

HOSPITAL COST DISTRIBUTION

Question. Hospitals recognize that they must share in controlling the cost of health care, however, they seem to be carrying the entire burden. It appears that a disproportionate amount of regulations are imposed on hospitals while suppliers are not sharing equally in the attempt to control health care costs. Will there be any plans implemented to distribute the burden of controlling costs more equitably to all parties involved?

Answer. Although it is true that this Administration has been able through the Prospective Payment System to bring hospital cost increases under control, there remain subsidies in the hospital system that are clearly excessive. These excessive payments must be addressed independently of the issue of increases in Part B. We believe that this is the appropriate time to correct these problems in Medicare payments to hospitals.

Approximately 39 percent of the spending restraints on hospitals proposed in the budget would simply extend expiring legislative authorities (pay capital at 85 percent of costs).

Unlike hospitals, where the government has been able to address most costs through a single overall approach, the Prospective Payment System, Medicare Part B is a very complex program for which no overall approach has yet been identified for controlling cost increases.

The Congress and the Administration are both searching for ways to being Part B program costs under control. The steps proposed in this budget are not expected to be the whole solution to the problem, but are measures clearly called for based on our current knowledge. We must find a way to control both inflation in fees as well as increases in volume for services of physicians and other suppliers.

WRITTEN QUESTIONS FROM SENATOR CONRAD TO SECRETARY SULLIVAN AND THE RESPONSES

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

Question 1. Could you please explain to the Committee why LIHEAP is targeted for cuts by the Bush Administration and what would the impact be on low income households if the cuts to LIHEAP envisioned by the Administration were enacted?

Answer. The FY 1990 budget request reduced LIHEAP by $283 million because of: the stabilization of energy prices, availability of oil overcharge settlements, households spending a smaller portion of their income on heat, State transfer of LIHEAP funds to other block grants, and high Federal budget deficits.

Because LIHEAP is a block grant which affords the grantees flexibility in designing their energy assistance programs, there is no direct correlation between reductions in Federal appropriations and households served. Thus, we are unable to estimate the impact on households served at any level of Federal appropriations. LIHEAP grantees may supplement their Federal appropriations with State or oil overcharge monies, not exercise their option to transfer funds out of LIHEAP into other block grants, eliminate a service component such as cooling or weatherization or reduce the size of the benefit provided.

COMMUNITY SERVICES BLOCK GRANT

Question 2. Since there is no specific level of funding in President Bush's budget on the Community Services Block Grant, what level do you recommend for this program?

Answer. The budget for 1990 did not include funding for the Community Services Block Grant.

Question 3. If you support cuts, how do you reconcile those cuts with requesting increased funding for homeless program?

Answer. President Bush proposes to fully fund the McKinney Act and to fund a new $50 million initiative to help reduce homelessness. Community Services Block Grants funds are largely used to provide services which are similar to those already funded under other authorities, including the Social Services Block Grant; the Low Home Energy Assistance program; and the Head Start program.

MEDICARE REDUCTION

Question 4. The FY 1990 request for funds to administer the Medicare program, submitted by President Reagan, proposed a substantial cut for ongoing operations. President Bush appears to cut these activities even further.

I understand part of this cut includes a 35% reduction in activities to protect Medicare from erroneous payments and in stemming fraud and abuse.

Last week, GAO testified before Senate Appropriations that these cuts would cost the Medicare program over $1 billion in misspent funds and in their words would be penny-wise and pound-foolish.

Since we all are concerned about the growth in Medicare payments and keeping the program affordable for Medicare beneficiaries, what is your view on these proposed cuts.

Answer. To live within the amounts proposed for Medicare operations, we had to address Congressional and Administration priorities. Functions which are legislatively mandated or which have legislatively mandated timeframes clearly must be fully funded. These functions include claims payment, hearings and the participating physician program. Also, we need to fully fund all activities associated with implementation of catastrophic health insurance and beneficiary services, where we expect a greatly increased volume of inquiries. Any reductions, therefore, had to be taken in the areas where there is greater discretion. As a result, the reductions were made in productivity investments and payment safeguards.

Even so, the FY 1990 Reagan budget included a 6 percent increase in funding for Medicare contractors. The Bush budget includes contractor funding in the residual freeze pool. It is our expectation that there will be programs in this residual category for which an alternative funding mix will be judged desirable and/or necessary. Within the program management account total and contractor activities, there is flexibility to reallocated funds to high priority areas.

NATIONAL HEALTH SERVICE CORPS

Question 5. At your confirmation hearing and today you testified that the National Health Service Corps was one of the bright spots in rural health. I agree with you whole-heartedly. The need for health services in rural areas is well documented. This program provides a start towards filling those needs.

I am quite concerned that the program is targeted for reduction by virtue of its inclusion in the "black box". Mr. Darman has stated that one way to balance the black box is to accept President Reagan's budget for the programs. Mr. Reagan cut more than 50% out of the funding. Do you agree with this cut?

Answer. Although the President's budget proposes a reduction to the NHSC, it is anticipated that this will be offset by State efforts under the loan repayment program which is maintained at the fiscal year 1989 appropriation level.

Question 6. If this program is indeed a bright spot, what future does it have under your leadership?

Answer. It is the Administration's position that these services are best administered at the State level.

WRITTEN QUESTIONS FROM SENATOR ROBB TO SECRETARY SULLIVAN AND THE RESPONSES

MEDICARE PAYMENTS TO TEACHING HOSPITALS

Question 1. Mr. Secretary, as a former medical school dean, you are well aware of the importance of training of medical professionals in teaching hospitals. Since 1981, Medicare payments to teaching hospitals have been annually targeted in the budget process. Many of these fine facilities have made great strides towards better management of health care delivery. How can you really justify proposing reducing payments to these hospitals?

Answer. The proposals in the Department's budget would, I believe, adequately compensate teaching hospitals for the direct and indirect costs associated with training interns and residents, but would eliminate excessive payments.

Teaching hospitals were initially provided additional payments to compensate for expected higher patient care costs. Our proposals would ensure that our payments more accurately reflect the estimated effect of teaching programs on average operating costs per case. Empirical data indicate that a more appropriate indirect medical education adjustment is in the 4 percent range. The General Accounting Office and the Prospective Payment Assessment Commission agree that a substantial reduction in payments is warranted.

Our estimates also indicate that teaching hospitals have consistently had the highest Medicare operating margins of any class of hospitals. Therefore, I will continue to support appropriate levels of reimbursement for the costs of medical education. The more realistic direct and indirect medical education adjustments that we propose would provide incentives for teaching hospitals to continue to reduce inefficient practice patterns and assure survival in a competitive health care system.

MATERNAL AND CHILD HEALTH

Question 2. Infant mortality ought to be an embarrassment to all of us. The United States ranks last among industrialized nations on infant mortality. In fact, infant mortality is a significant issue in the shadow of the U.S. Capitol. Nearly one out of three women in the United States do not receive sufficient prenatal care during pregnancy. Approximately one half of black and non-white women do not receive sufficient prenatal care. President Bush proposes a new $20 million grant program for demonstration programs designed to combat infant mortality. That is the good news. The bad news in that the Maternal and Child Health Block Grant is in the "Black Box." Under the President's budget outline, what would be the proposed budget for this program.

Answer. The FY 1990 budget for the Maternal and Child Health Block Grant is $554,268,000, the same level appropriated in FY 1989.

MEDICAID

Question 3. President Bush, in his budget outline, proposed a significant reduction in Medicaid administrative payments to States and to use most of the Federal savings to finance incremental improvement in coverage for pregnant women and children. While these improvements are to be applauded, the entire cost would be at the expense of the States. Mr. Secretary, do you or the President really believe that all of the States will absorb the costs and not reduce services in the Medicaid program?

Answer. Yes. Research has shown that programs designed to reduce infant mortality and morbidity and to promote immunization have long term benefits and savings. These programs decrease neonatal intensive care days in the hospital and decrease the incidence of childhood diseases and debilitating disabilities. The long term costs of providing care for the ill and disabled infants and children is often borne by the States. These Medicaid proposals would assist the States in addressing some of the root causes of infant mortality and childhood diseases.

The special administrative matching rates were initially conceived to assist States in meeting new administrative objectives to the Medicaid program. For the most part, States have now met these objectives. Therefore, higher matching rates are no longer justified.

BIOMEDICAL RESEARCH

Question. As a former medical school dean, you know the importance of National Institutes of Health in the field of biomedical research and training. The President's Budget outline appears to propose a funding level about $50 million below the Gramm-Rudman-Hollings FY 1990 baseline levels. The budget committee staff believes that about $200 million more would be needed to continue current levels of research grant awards. Mr. Secretary, do you agree with this assessment?

Answer. The President's budget requests a 5.7% increase for research project grants compared to FY 1989. The NIH estimates that it cost approximately $125 million to fund the same number of competing research project grants as will be funded in FY 1989, at the same level of downward negotiations.

Question. How many research grant awards do you feel can be awarded under the President's budget?

Answer. Under the President's budget request for FY 1990 the NIH will be able to fund a total of 19,773 non-AIDS research project grants, 15,217 noncompeting and 4,556 competing. This is 1,518 more than the average number of total awards per year made from 1982 to 1989.

COMMUNITY AND MIGRANT HEALTH CENTERS

Question. Mr. Secretary, Community and Migrant Health Centers provide the vital health services to over 5.1 million persons in this country. According to the National Clearinghouse for Primary Care Information, approximately 64% are members of minority groups—Blacks, 31%, Hispanic, 28%; and other, 5%. Forty-five percent of those served are children under age 20; 46% are in the 20 to 64 age group and 9% are 65 or over. About 60% of Community Health Center users have incomes under the poverty level and another 25% are between 100 and 200 percent of poverty. President Bush's budget outline seems to suggest that the Community and Migrant Health Centers programs would also be in the "Black Box" of programs to be discussed. Given the importance of this program, what level of funding are you proposing for FY 1990?

Answer. The FY 1990 request for Community Health and Migrant Health Centers is $460 million, the same as was appropriated in FY 1989. The President's request also provides an additional $12 million for the Infant Mortality Initiative funded through the Centers, and $48.8 million for Health Care for the Homeless, over the FY 1989 levels of $20.6 million and $14.8 million, respectively. In addition, the FY 1990 budget included a new $10.9 million initiative to provide primary care services for AIDS patients.

MEDICARE STATE AND LOCAL COVERAGE

Question. President Bush's budget outline proposes to extend Medicare payroll taxes to State and local government employees hired before March 31, 1986. The proposal would increase revenues by about $2 billion. This proposal was repeatedly submitted by former President Reagan, and the Congress repeatedly denied it. What is the justification for this revenue increase?

Answer. We believe that the proposal does not violate President Bush's prohibition against new tax increases. The proposal does not change tax rates but instead closes a costly loop hole through which may state and local employees receive Medicare benefits without paying their fair share of the Medicare tax.

As you know, Congress mandated Medicare coverage and payment of Hospital Insurance taxes for new State and local government employees hired after March 31, 1986. Many state and local employees, hired prior to that date, become eligible for Medicare on the basis of short periods of work covered by Social Security or by entitlement through a spouse. In fact, a recent report by the Department's Inspector General found that 85 percent of sampled retirees from State and local agencies were not covered by Medicare but were enrolled in Part A. Our proposal would also offer Medicare coverage to state and local government workers who now have no opportunity to enroll.

MINORITY STUDENT ASSISTANCE

Question. The National Health Service Corps is a program that was created by Congress in 1972 to ensure that communities throughout the Nation that suffer from a severe shortage of health professionals—physicians, nurses, dentists—would be adequately served. Scholarships were provided to students during their period of graduate medical education in return for their promise to provide service in a health manpower shortage area upon graduation. Members of Corps serve in some of the poorest and most severely underserved communities in the United States. Mr. Secretary, as you know, many black medical school graduates were able to pay high tuition bills through utilization of these scholarships. No scholarships are available. Does the President have any plans to again assist needy minority students seeking a medical education? In answering this question, keep in mind that I am aware of Administration attempts to greatly restrict current higher education grant and loan programs.

Answer. The Health Resources and Services Administration has several programs that can provide financial assistance to minority and disadvantaged students. The Bureau of Health Profession's health professions and nursing revolving loan funds will make approximately $86 million for loans to about 32,500 students. The budget also includes $100 million in loan guarantee authority for the HEAL program to support 10,000 health professions student borrowers.

The Department of Education's Guaranteed Student Loan Program, and other loan and scholarship resources available through State and local government programs and private endowments are also available to minority and disadvantaged students.

MEDICAID LIABILITY

Question. What is President Bush's position on liability concerns with regard to the Medicaid program?

Answer. The President is concerned that some physicians may not want to participate in Medicaid due to the perception of increased malpractice liability. As a result, the Department has made provider recruitment and retention a priority issue of the Medicaid maternal and infant health initiative. HCFA is now actively addressing this issue in cooperation with the Public Health Service, the National Governors' Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics.

WRITTEN QUESTIONS FROM SENATOR DOMENICI TO SECRETARY SULLIVAN AND THE RESPONSES

CATASTROPHIC HEALTH INSURANCE

Question. With regard to the catastrophic health legislation that passed last year, do you believe the supplemental premium that was included in the tax code to finance over one-half of the cost is appropriate?

Answer. Catastrophic health insurance provides all Medicare beneficiaries with protection from large hospital, physician, and outpatient prescription drug bills resulting from a prolonged or particularly expensive acute illness. All Medicare beneficiaries are at risk of such an occurrence, and thus all beneficiaries benefit from the protection catastrophic health insurance provides.

We are aware of the criticism leveled by some that the financing mechanism is unfair, but we believe that as beneficiaries become more fully aware of the value of their new benefits, concern over financing will subside. And it is important to remember that only some 45 percent of beneficiaries will pay the supplemental premium and only 8 percent of beneficiaries will pay the maximum supplemental premium.

I would also point out that the bulk of Part A benefits are paid for by current workers and employers through a payroll tax, and 75 percent of part B benefits are paid for out of general revenues. The financing of the new catastrophic benefits was deliberately designed to avoid imposing additional tax burden on current workers.

Question. According to your agency's estimates, is the financing for this bill sufficient to cover the costs in the long run? Could you explain why your estimates differ from those of the Congressional Budget Office?

Answer. The financing of the non-drug catastrophic benefits is adequate through 1993 while the financing of the drug benefits for the same period is not adequate. HCFA is currently analyzing all of the implications of financing Catastrophic benefits after 1993 and cannot comment at this time.

HCFA's estimates for the non-drug portion of the Catastrophic legislation are fairly consistent with CBO. The differences which occur between the HCFA and CBO drug benefit estimates primarily result from two factors. First, HCFA uses a mean expenditure for drugs which is higher than CBO's. Second, HCFA's "insurance effect" is higher than CBO's. By this, we are referring to the amount of increase in utilization due to the fact that Medicare would now pay a substantial portion of drug expenses (once a beneficiary meets the deductible).

Question. Do you plan to review this legislation, and offer a specific endorsement or recommendations for change?

Answer. The Department of Health and Human Services strongly supports catastrophic health insurance for Medicare beneficiaries. We believe that it is important to protect all Medicare beneficiaries against the potential for financial ruin when a catastrophic illness strikes.

Naturally, all new legislation is subject to review after it has been implemented and its effects can be measured, but we have no plans to recommend changes in the catastrophic provisions.

MEDICARE COST GROWTH

Question. Could you shed some light on why Medicare costs are expected to grow by 12 to 15 percent a year if no changes were made to the program?

Answer. There are four major reasons for growth in the Medicare program. First, the Medicare population continues to grow at a fairly steady 2 percent per year, and that population itself is aging. This increases the number of recipients of services. Second, the costs of medical care increase each year along with inflation in the economy; these costs include both supplies and wages of personnel. Third, the volume of services continues to rise; that is, more serious are provided to each beneficiary who seeks medical care. And fourth, the intensity of services continues to rise; that is, more highly sophisticated and more expensive technologies and procedures are being substituted for less sophisticated and less expensive ones. These factors combined result in unacceptably high annual growth rates in the Medicare program. We will continue to seek ways to control these growth factors in ways that will continue to assure access to high quality services for Medicare beneficiaries.

Question. Why does limiting the growth rate in Medicare to 9 percent as the Bush Budget proposed require price freezes and deep cuts (nearly $5 billion) to health care providers when enrollment growth is less than 2 percent and inflation only 4 percent?

Answer. The Medicare budget proposals are necessary to restrain the growth of Medicare spending, which would otherwise grow by 14 percent in 1990, despite an enrollment growth of only 2 percent and inflation in the economy of only 4 percent. In large part, Medicare increases in volume and intensity of services result in cost increases greater than the combination of these two factors (enrollment and cost increases).

It is important to note that three of the budget proposals—the 85 percent capital payment, the 25 percent Part B premium floor, and limits on clinical laboratories—merely retain policies that are now part of current law. These proposals would save approximately $2 billion. The remaining $3 billion in savings represents a restraint on Medicare growth of only 3 percent. No actual cuts are being proposal, only a restraint on growth of 3 percent.

Question. What steps, beyond those included in the Bush Budget, need to be taken to shore up the hospital insurance trust fund, now projected to go broke in 2005 under intermediate projections?

Answer. Efforts to restrain the growth of the Medicare program have extended the Trust Fund's solvency from the early 1990's to the next century, about 2005. Constraining growth in hospital insurance outlays will remain a priority. We will continue to work with Congress to develop innovative improvements and structural reforms for the Medicare program to ensure its financial soundness.

MEDICARE PROPOSALS

Question 7. Do you plan to review the Reagan proposals to achieve $5 billion in Medicare savings and perhaps offer alternatives?

Answer. As I stated in my testimony, we are not necessarily wedded to these specific proposals and would be willing to consider others that would achieve the objective of slowing the growth of Medicare expenditures. We are willing to discuss other approaches with the Congress. But, we cannot let the Medicare program continue to grow at a 14 percent annual growth rate. To do so threatens the financial viability of other needed initiatives as well as the tolerance of the taxpayers to continue to support these important programs.

Question 8. Do you plan to submit legislation to implement the Reagan proposals or other Medicare proposals?

Answer. Proposed legislation to implement the Medicare proposals in the 1990 budget was sent to Congress on March 1, 1989.

Question 9. Do you think the proposals to modestly expand Medicaid coverage to pregnant women and infants below 130 percent of poverty is sufficient?

Answer. Although coverage to any level of poverty does not necessarily guarantee that all individuals needing medical care will receive it, this proposal is certainly a step in the right direction. We anticipate that eventually this proposal will cover an additional 240,000 pregnant women and infants. President Bush is committed to improving health care for low-income Americans, particularly mothers and their infants, but this must be accomplished within very tight fiscal restraints.

In addition to expanding eligibility to more low-income pregnant women and infants, we will also be working to provide states with guidance, training workshops, encouragement and hands-on state by state help to implement new coverage options.

Question 10. Is this the first stop to a larger expansion of Medicaid that the administration will support?

Answer. The budget we are submitting is for FY 1990. We will address issues for 1991 when we submit that budget early next year.

Question 11. What is the rationale for offsetting the added costs of the Medicaid expansion by limiting reimbursement to States for administrative costs?

Answer. The special administrative matching rates were initially conceived to assist states in meeting new administrative objectives in the Medicaid program. The objectives have for the most part been met, so higher match rates are no longer justified.

We believe that the health care needs of low-income pregnant women and young children are compelling and that the savings derived from outdated administrative matching rates can be applied to this pressing need without harming beneficiaries.

DISCRETIONARY PROGRAMS UNDER FREEZE

Question 12. OMB Director Darman has indicated the agencies were welcome to submit proposals for spacing in the residual "freeze"; category as long as overall outlay caps were not breached. Dr. Sullivan, do you plan to take OMB Director Darman up on his offer that you can propose for spending levels for your discretionary programs that were included in the freeze category as long as you do not exceed certain totals?

Answer. Only 10 percent of HHS programs are in the flexible freeze category. At the present time, I have been reviewing budget options to present to Mr. Darman, but I have not as yet made any definite decisions.

Question 13. In what time frame would we expect these proposals?

Answer. I will notify this Committee of any funding decisions in the flexible freeze area. We will be happy to negotiate funding for these programs with the Congress.

Let me assure you that this issue is very important and will receive early consideration. You will be notified as soon as possible about these decisions.

Question 14. What programs are on your high priority list?

Answer. Ninety percent of HHS programs are included in the President's priority category. They are:

Public Health Service

AIDS
Drugs
Homeless
Adolescent Family Life
NIH
FDA user fees

Health Care Financing Administration

Medicaid
Medicare (excluding admin.)
HMO Loan Fund

Social Security Administration

SSI (excluding admin.)
Black Lung
OASI (excluding admin.)
DI (excluding admin.)

Family Support Administration

Family Support Payments (FDC/CSE)

Office of Human Development Services

Head Start
Adoption Assistance
Homeless
Adoption Opportunities

In addition, as I pointed out in my opening statement, I will focus heavily during my tenure on health promotion and disease prevention, establishing opportunities for minority entrance into the health professions and enhancing our biomedical research capabilities.

NIN RESEARCH GRANTS

Question 15. Are you concerned with the increasing cost of research grants at the NIH? Do you have any suggestions?

Answer. The Department has been concerned for the past several years about the apparent rise in the cost of research project grants at the NIH. The Public Health Service (PHS) conducted a study on research costs in 1985 and the HIH has conducted several studies on this issue. When reviewed over time, the rise in average costs are relatively small. For example, the yearly grant increase in the average cost of research project grants from FY 1980 to FY 1988 averaged about 1.7 percent in real terms. This is not unreasonable in a time of growing complexity of research.

The Office of the Inspector General (OIG) has just completed the first phase of a report requested by the House Appropriations Committee concerning the cost of research grants. The report includes some initial recommendations for potential cost savings that will undergo further review in the second phase of this study.

SCIENTIFIC STAFF RETENTION

Question 16. Do you have any thoughts about problems at NIH and ADAMHA with Scientific staff retention and recruitment?

Answer. Recruitment and retention of highly qualified scientific staff at the National Institutes off Health and at the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) is a serious problem. As my distinguished predecessor, Dr. Otis Bowen, wrote last year when he recommended legislation establishing a Senior Biomedical Research Service, . . ." Our research programs are in grave trouble because we simply cannot compete for leading physicians and in biomedical scientists."

Recent recruitment and retention problems in ADAMHA include: failure to attract a qualified scientist as Chief, Laboratory of Physiologic and Pharmacologic Studies; failure, despite 19 months effort to attract a senior investigator in AIDS/immunology; loss of M.D. and Ph.D scientists in the National Institute on Alochol Abuse and Alcoholism Laboratory of Clinical Studies; and expenditure of inordinate amount of time be science managers in seeking qualified candidates here and abroad. In addition, difficulty in attracting qualified people from outside the Agency for management positions has resulted in a brain drain from intramural research programs and a tendency to fill management positions with poeple who lack certain experience.

So I think the Senior Biomedical Research Service represents one approach to continue to maintain excellence in biomedical and behavioral science and science leadership. Naturally, I am prepared to consider other approaches based on one Institute of Medicine study on how to assure continued excellence in our science programs.

MATERNAL AND CHILD HEALTH

Question. President Bush has left the maternal and child health Block Grant in the "residual freeze" category. Do you consider this program a priority?

Answer. In identifying health priorities for FY 1990, the President included drugs, homeless, adoptions, AIDS, biomedical research, and improved medicaid for pregnant women, infants and children. It is clear this Administration will support efforts to reduce the nation's infant mortality rate. The Maternal and Child Health Block Grant is one mechanism through which we support State efforts in this area.

Question. How do you plan to assess funding needs for this program and assure that these needs are met?

Answer. Review of the 1990 budget request will include an evaluation of the Department's maternal and child health activities.

Question. Are there other things, perhaps without a budget cost that HHS can do to improve the health care of low income, pregnant women and infants?

Answer. We support a number of other activities and programs which contribute to the improved health status of pregnant women and infants. These include the community health centers program, and research at the National Institutes of Health and at the Alcohol, Drug Abuse and Mental Health Administration.

RURAL HEALTH CARE ACCESS

Question. Do you have any thoughts on how we can help assure access to Health care for our citizens in rural America?

Answer. First, we need to do everything we can to remove barriers that discourage medical professionals from practicing in rural areas, particularly differences in Medicare payment rates. We need to address the Medicare payment differences between primary and non-primary care services. Most of the health professionals needed in rural areas are primary care specialties, and when we have an insufficient number of these professionals, rural areas suffer more than urban areas.

Second, we need to examine the equity of the Medicare payment difference between urban and rural hospitals.

And third, we also need to continue to target personnel available through the National Health Service Corps to rural areas.

Question. Are there ways to help rural health care other than more Federal dollars?

Answer. Yes, there are ways to help rural health care other than more Federal dollars. In particular, changing the relative Medicare payment rates for physicians would only shift the balance; it would not require more Federal outlays.

Question. The Reagan budget proposals for Medicare did not treat rural health providers differently than other providers. This implies to me that HHS either believed that there are not unique problems facing rural health care or that Medicare should not be used to address them. Dr. Sullivan, what is your view?

Answer. I am very concerned about access to care for beneficiaries who live in rural areas. However, I also recognize that the problems facing rural hospitals are complex and that Medicare should not be viewed as the sole means of assuring financial viability for these hospitals.

Rural America is undergoing change. A declining population, recession in the agricultural sector, and individuals seeking care at urban hospitals all have had an adverse effect on the financial health of rural hospitals. Medicare and non-Medicare admissions to rural hospitals have declined about 17 percent between FY 1984, the first year of PPS, and FY 1987, twice as much as urban hospitals. Many rural hospitals suffer from low occupancy rates (41 percent on average in FY 1987) with accompanying high staffing ratios.

Recent changes in the PPS payment methodology were designed to reduce the urban/rural inequity and increase total payments to rural hospitals. In addition, the Department is implementing a Rural Health Transition Grants Program that is designed to support the planning and implementation of specific changes, programs or activities a hospital and its community can undertake to strengthen access to necessary care for Medicare beneficiaries. A demonstration program is already underway in Montana to test alternative health care delivery.

Question. Are you satisfied that the U.S. is getting a fair return for what it spends on health care?

Answer. In general, I am satisfied that the U.S. is getting a fair return for what it spends on health care. However, that does not mean that improvements are not possible. Studies have shown significant overutilization and inappropriate utilization of services. I am concerned about overutilization and inappropriate utilization of services not only because it generates unnecessary costs, but also because it causes increased and unnecessary risk to patients who undergo these services. We are aggressively pursuing the Medical Treatment Effectiveness Initiative, which should provide much-needed information about appropriate utilization of medical services and help us to better target health care resources.

We also must do something about the rising costs of Medicare. If no spending restraints are imposed, Medicare benefit outlays will grow at a rate of over 14 percent in 1990. Medicare Part B costs have increased at a rate of 15 percent per year for the past decade. These growth rates must be brought under control. We cannot allow Medicare to continue to grow at this rate. A 14 percent annual growth rate will result in Medicare outlays in 1995, only five years away, of over $200 billion. This level of growth will make any new initiatives very difficult, if not impossible to achieve.

In addition, we need to do everything we can to remove barriers that discourage medical professionals from practicing in rural areas, particularly differences in Medicare payment rates. We need to address the Medicare payment differences between primary and non-primary care services. Most of the health professionals needed in rural areas are primary care specialties, and when we have an insufficient number of these professionals, rural areas suffer more than urban areas.

And last, we need to stress health prevention and health promotion more strongly. I believe that individuals need to take more responsibility for preventing illness by taking the steps necessary, such as immunizing their children, improving their nutrition, and getting appropriate amounts of exercise.

Question. Is there a way to get a bigger bang for our buck? Are there basic reforms to our health care system that you advocate or think merit further attention?

Answer. In the U.S., we have emphasized high technology medicine in our health education systems and in our health care systems. When you look at where the most advanced medicine is available, it is here in the U.S. But perhaps we have erred in pushing our health system too heavily toward the specialty high technology areas. As a nation, perhaps we have come up against the ceiling of reality in terms of funds that are available.

I propose that we develop a strategy to provide health services that would benefit the largest number of people and concentrate more on such things as primary care services, health education, health education, health promotion, and prevention of illness. This approach would increase the number of people served and the potential impact on health status would be much greater than under our present approach. I think we need to take a hard look at shifting the emphasis in the health system in our country more toward primary care, health promotion, and prevention of illness.

WRITTEN QUESTIONS FROM SENATOR GRASSLEY TO SECRETARY SULLIVAN AND THE RESPONSES

MEDICARE PROPOSALS

Question. I would like to ask a question about the level of savings the Administration is proposing for the Medicare program for the coming budget year.

Whereas a year or two ago it was mainly small, rural hospitals that complained that they were losing money on Medicare patients, now *both* our urban and rural hospitals are complaining that they are not making anything, or very little, for treating Medicare patients.

About sixty percent of the Administration's proposed $5.2 billion in savings will come from hospitals. Can we realize savings of this magnitude without jeopardizing the quality of care or access to care in hospitals?

Answer. I am committed to ensuring that Medicare beneficiaries continue to have access to quality health care. The hospital savings we have targeted are in areas where we believe there remain unnecessary spending. For example, we believe that we can no longer afford to pay hospitals for the full cost of capital and that paying less gives hospitals a strong incentive to evaluate their capital investments. Direct and indirect medical costs and costs for graduate medical education are also paid on the basis of cost and continue to provide unwarranted subsidies to hospitals. We believe restraints in these areas, where payments are not yet included in the PPS rate, are necessary to eliminate excessive spending.

Question. Let me pursue this question with respect specifically to the inequities in the prospective payment system which adversely affect small rural hospitals.

I think that, by now, most interested parties think that many small, rural hospitals face serious financial problems which could jeopardize their existence.

In Iowa, we've lost one hospital and another community had to raise money by public subscription to keep their hospital going. This is a small number compared to the experience of some States, like Texas, for instance. Nevertheless, the possibility that we in Iowa could be on the verge of losing a large number of hospitals makes some of us very nervous because the hospital can be the linchpin of health care in a community. Would the Department support a larger update factor for rural hospitals as has been recommended by the Prospective Payment Review Commission?

BENTSEN/DOLE BILL

Question. Beyond that, I would appreciate knowing the Department's reaction to the Bensten/Dole Bill, S. 306, which envisions phasing out the urban-rural distinction by 1994. I understand that you will probably not have had an opportunity to review this bill in detail.

Answer. We have acknowledged that rural hospitals have been disadvantaged in the past by PPS and we have implemented major changes to "level the playing field". However, since most of the changes take effect in FY 88 and FY 89, we do not have available data to ascertain the effects of these changes. While we are committed to making the PPS as fair as possible, we do not believe that increased Medicare payments is the only viable alternative for some rural hospitals. While I have not reviewed S. 306 in detail, I support its goals of making PPS as equitable as possible and preserving access to quality health care in rural areas.

RURAL HEALTH ACTIVITIES

Question. As you probably know, there is an active Rural Health caucus in the Senate of around 50 members. I think it is safe to say that this group has been interested in several activities in the Department relating to Rural Health. These include the office of Rural Health and its National Advisory Committee, and the Rural Health Research Centers program.

These activities do not amount to much in budget terms. But some of us would like to be sure that you will provide them, particularly the work of the Office of Rural Health and the National Advisory Committee, a high priority in your Administration of the Department. Can you give us assurances on that point?

Answer. The Department of Health and Human Services' commitment to Rural Health initiatives will continue to have a high priority in our agenda. The Department has already corresponded with the chairman of the National Advisory Committee on Rural Health, former Governor Robert Ray of Iowa. We hope to meet with Governor Ray and that Committee later this year. We know that the Committee plans to make some recommendations that we will consider carefully. We also support the Office of Rural Health policy's work in facilitating solutions to Rural Health problems and staffing the National Advisory Committee. Let me assure you that we have every intention of continuing the office.

HEALTH PERSONNEL FUNDING

Question. The Administration's Budget Submission accepts the Reagan Administration's Budget Proposal not to fund many health personnel training programs.

Given that we have what appear to be severe shortages of certain health care professionals, such as nurses and allied health personnel, why should we reduce funding for health professions training?

Answer. We have had much success in increasing the supply of health professionals. In view of the Administration's priorities in relation to the budget deficit and the targeting of limited Federal resources to other priorities, such as AIDS, biomedical research, and alcohol and drug abuse, the Administraton proposes not to fund health professions programs. Compared to such concerns as AIDS, the health professions programs is somewhat less pressing and somewhat more amenable to alternative sources of funding support. We will continue to support the underwriting of health education through our two revolving loan funds (HPSL and NSL), The Health Education Assistance Loan program (HEAL), loan repayment programs administered by States, and a variety of programs in the Department of Education.

MEDICARE

WEDNESDAY, MARCH 8, 1989

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuance to notice, at 1:39 p.m., in room SD-608, Dirksen Senate Office Building, Hon. Jim Sasser (chairman of the committee) presiding.

Present: Senators Sasser, Exon, Simon, and Grassley.

Staff present: John L. Hilley, staff director; and Kathy Deignan, assistant director for human resources.

For the minority: G. William Hoagland, staff director; and Jeff Sanders, senior analyst for social security, medicare and health.

OPENING STATEMENT OF CHAIRMAN SASSER

Chairman SASSER. The committee will come to order.

I am advised that our ranking member, Senator Domenici, will join us later and he has suggested that we go ahead and get under way and he will be with us as soon as his schedule will permit.

This afternoon, the Senate Budget Committee will continue its hearings on the 1990 health and human services budget that is being proposed by the Bush administration.

Now, the focus this afternoon will be on the medicaid and medicare portions of the 1990 budget and, as I said this morning when the Secretary of Health and Human Services was before us, I am deeply concerned about the depth of the medicare reductions in the budget proposed by the Bush administration. The President proposes to reduce the program, that is, medicare, by some $5.2 billion this year and some $57 billion over the next 5 years.

The administration contends that these reductions can be made without harm to the medicare program. Frankly, I do not share that view. To a large extent, I suspect neither do the witnesses who appear here today, who are most familiar with the medicare program.

Now, I believe that we must continue to find prudent ways to reduce spiraling health care costs. It is plain that that, absent changes in the medicare program, part A payments to hospitals will increase by 10 percent a year for the next 5 years, and part B payments under medicare are projected to increase by 16 percent a year in the next 5 years.

These cost increases are well above the rate of inflation, and unless this growth rate in health care costs is restrained and restrained in a reasonable fashion, it could threaten the entire medicare program. So, we must find every acceptable means of reducing health care costs that do not reduce the right of medicare beneficiaries to high-quality health care.

So, we need the best facts available about effective ways of reducing health care costs in both a responsible and equitable way. The hearing this afternoon is designed to help us sort out the facts and hopefully to make some informed choices—for this year's budget and in the future years as well.

Now, right now we are being asked to make deep budget cuts in the medicare program—cuts that are chipping away at the present medicare structure, without offering any real and enduring solutions to the health cost inflation program.

Now, I can tell you today that there may very well be some medicare reductions this year. I cannot say there will be no medicare reductions. But I can tell you that the Budget Committee will not reduce the program by $5.2 billion, as the Bush administration has suggested. Rather, we intend to examine the program carefully and only agree to reductions which can prudently help restrain the health cost care spiral.

I am confident that our witnesses today will shed considerable light on the impact of the Bush budget on medicare services, as well as on more effective ways to hold down the health care costs that are subject to medicare reimbursement.

I want to welcome today on our first panel Dr. Paul Ginsburg, Executive Director of the Physician Payment Review Commission, who will tell us what is happening with the medicare part B program, and Mr. Bruce Steinwald, Deputy Director of the Prospective Payment Assessment Commission, charged with advising Congress on medicare hospital reimbursement.

Gentlemen, we are pleased to have you here today. I thank you for your attendance. We will begin with Dr. Ginsburg, and I am told on good authority that Dr. Ginsburg's wife is expecting a baby momentarily, so if you get up and rush out of the room—have I got the right one?

Well, I thought Dr. Ginsburg had sort of a pale expression on his face——

[Laughter.]

A flash of terror went across his face when I said that. It is Mr. Steinwald. So, if Mr. Steinwald gets up and rushes out of the room, we will all know what that is about. Well, Mr. Steinwald, we will start with you first today, because you may have to leave early. Give Dr. Ginsburg's heart time to slow down from that last pronouncement. [Laughter.]

STATEMENT OF BRUCE STEINWALD, DEPUTY EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. **Steinwald**. Thank you, Mr. Chairman. I am here on behalf of ProPAC's 17 Commissioners who, as you stated earlier, have the responsibility for advising the Department of Health and Human Services and the Congress on the updating and maintenance of the medicare prospective payment system, the system that is currently in use and has been since the beginning of fiscal 1984 to pay for hospital inpatient hospital services received by medicare's beneficiaries.

The prospective payment system, as you know, Mr. Chairman, is a fixed-price payment system. The fixed prices are based on the patient's diagnosis and other factors and are termed diagnosis related groups. The payments that hospitals receive are adjusted for variations in labor costs and there are other adjustments in the system.

The system is now in its sixth year, and I would like to begin my summary of the testimony with a brief review of the experience of the first 5 years, and then I will go on to a summary of the Commission's recommendations for fiscal year 1990.

During these 5 years of the prospective payment system, inpatient spending under medicare has been moderated. That moderation, however, has been due principally to the decline in the rate of admissions of medicare beneficiaries to hospitals more than any other factor.

On a per case basis, the experience of the first 5 years has been a very mixed experience, and at this time I would like to turn your attention to exhibit 1 in the prepared testimony[1] delivered to the Committee, which shows some of the factors over the first 4 years of the program, financial factors that have affected hospital reimbursement and hospitals 'financial performance.

Initially, under the prospective payment system, hospitals did very well. The rates established in fiscal 1984 were generous, and during that year hospitals were able to cut their costs. As a consequence, during at least the first 2 years of the prospective payment system, most hospitals did very well financially.

After the first 2 years, however, the picture changed, and even though hospitals' revenues did indeed go up over the latter part of that period, their costs went up at a faster rate than their revenues. Consequenctly the overall financial position of hospitals under the prospective payment system right now is not nearly as good as it was during the first 2 years. That overall financial position is portrayed in exhibit 2.[2] As you can see, Mr. Chairman, exhibit 2 presents what we call revenue margins and these revenue margins pertain exclusively to the prospective payment system. They do not include revenue from other sources.

Hospitals, on average, earned revenues of nearly 15 percent in the first 2 years, declining precipitously after the first 2 years, until last year, the year that we have noted as PPS5. We believe that hospitals' average margins under the prospective payment system fell to about zero, and this year, when we have our data in, we believe that the average margin will be substantially below zero. And the reasons for this experience are twofold.

While the rates of increase in revenues to hospitals have been slow during the past 3 years, the rates of increase in their costs have been much higher than expected. Hospitals' costs per case under medicare have increased at the rate of approximately 10 percent per year for 4 years, and that 10 percent per year is 6 percentage points above the average rate of inflation in the goods and services hospitals purchase.

Consequently, it is indeed true that hospitals' financial position under the prospective payment system is poor, and I would also like to add that these averages mask a substantial amount of variability across hospitals. Even during the current year, when the average margin we believe is below zero, many hospitals are still earning profits, and yet other hospitals are experiencing substantial losses.

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[1] See p. 257.

[2] See p. 258.

Well, with that information as a backdrop, I would like to now go on to summarize the Commission's recommendations for the fiscal 1990 payment rates.

The Commission recommends an average payment increase of 4.9 percent. That average of 4.9 percent is .8 percent below the predicted market basket inflation rate in the goods and services that hospitals purchase, and that average of 4.9 percent consists of a 5.0-percent recommended increase for hospitals in large urban areas of over a million population, a 4.5 percent increase for hospitals in other urban areas, and a 5.6 percent increase for rural hospitals.

These increases are illustrated in exhibit 3[1] in the prepared testimony and, as you can see from exhibit 3, there is a methodology by which the Commission arrives at its recommended increase that I will not go into now, but would be happy to explain later if there is time.

Each year, recommending an update in the payment rates is our principal responsibility, but the Commission also undertakes other issues affecting hospital payments under the prospective payment system, and I would like to highlight two of the issues that the Commission addressed this year.

First is the matter of the indirect medical education adjustment and, as you noted yourself, Mr. Chairman, the President's budget proposes reducing that adjustment nearly in half.

The Commission undertook its own investigation and did indeed find that there was a basis for lowering the adjustment, but does not recommend lowering it as much as the administration has proposed. At present, the adjustment is based on a formula where hospitals with an interns and residents per bed ratio of 0.1 receive a 7.7 percent add-on to their prospective payments, and hospitals with more interns and residents per bed receive a higher add-on and those with less receive a lower add-on.

We would propose reducing that indirect medical education adjustment down from 7.7 percent to 6.6 percent, and the Commission would also propose making that reduction budget neutral by returning the savings to the base for payments for all hospitals.

Now, our analysis actually did support lowering the indirect medical education adjustment even further, perhaps down as low as a 4.4 percent level, but the Commissioners were concerned that that was too precipitous a decline for teaching hospitals in any one year, and they also were concerned that it would affect the overall financial welfare too adversely for many teaching hospitals, especially those which serve a disproportionate number of poor people.

Consequently, we are recommending a modest reduction this year, with the intent to continue our analysis in future years to determine whether any further reduction is warranted.

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[1] See p. 259.

Mr. Chairman, the final issue I would like to discuss has to do with the rural hospital question and the number of problems faced by rural hospitals.

I have already noted that the Commission recommends that rural hospitals should continue to receive a higher update under PPS than urban hospitals. But the Commissioners also wanted to stress in their recommendations this year that the problems faced by rural hospitals are not simply problems created by the medicare program, and therefore the solution to rural hospitals' problems cannot be entirely solutions that are related to medicare reimbursement policy.

We intend to continue to examine rural hospital problems. We intend in particular to look at the number of rural hospital closures, to make an assessment of the extent to which those closures represent a threat to access to needed services of medicare beneficiaries, and we intend also to look further into the question of whether the payment rates and the urban-rural rate differential is fair for rural hospitals or ought to be adjusted in the future.

Mr. Chairman, that ends my prepared remarks and I would be glad to take any questions.

Thank you.

Chairman SASSER. Thank you, Mr. Steinwald.

[The prepared statement of Mr. Steinwald follows:]

TESTIMONY

Before the

COMMITTEE ON THE BUDGET

U.S. SENATE

March 8, 1989

Bruce Steinwald
Deputy Executive Director
Prospective Payment Assessment Commission

Good Afternoon, Mr. Chairman. I am Bruce Steinwald, Deputy Director of the Prospective Payment Assessment Commission. I appreciate this opportunity to testify this afternoon on behalf of the Commission. As you know, ProPAC is an independent agency. Our 17 Commissioners, who have expertise in health care delivery, financing, and research, are appointed by the Office of Technology Assessment. We provide advice and assistance to the Congress and the Secretary of Health and Human Services on the Medicare prospective payment system, the system that pays for beneficiaries' inpatient hospital services.

The Medicare PPS is now in its sixth year. The move from cost-based reimbursement to PPS offered new opportunities and challenges to the government and to hospitals. On balance, ProPAC believes that many of the goals of PPS have been met and the system has functioned well. However, many problems and challenges remain with us today.

My testimony today covers three major areas. First, I will very briefly review how PPS works, including the annual updating of payments and the policy areas that affect the distribution of payments to hospitals. These issues are sufficiently complex that even those of us who work with them every day have a difficult time keeping up. As I point out, however, these policies are very important in ensuring that Medicare policy is fair to all hospitals.

Next, I will summarize some of the effects of PPS on the Medicare program and hospitals over the past 5 years. During this time the rate of increase in Medicare expenditures for inpatient hospital services has moderated, due primarily to a decrease in hospital admissions. At the same time, while hospitals did well financially in the early years of PPS, more recently their financial condition has deteriorated. This is related in part to constraints on Medicare payments. But it is also due to continued large increases in hospital costs. In addition, I will describe some important issues that affect the relative distribution of hospital payments. The most visible of these in recent years has been the different update factors that have been applied to rural and urban hospitals.

Finally, I will describe ProPAC's recent recommendations for updating the PPS system for fiscal year 1990.

Before I address these issues, I think it is important to put the Commission's deliberations in context, particularly because this Committee has responsibilities related to review and decision making on the entire Federal budget. ProPAC decided during its first year, 1984, that while budgetary pressures were critical, it was not the role of the Commission to explicitly address this concern in its deliberations. Rather, in all of its recommendations over the years, the Commission has sought to provide Congress and the Secretary with judgments that reflect our mission as outlined in the PPS statute.

The Commission has tried each year to recommend a tough but appropriate update factor that will encourage hospitals to be efficient in the delivery of high quality care. In fact, in each of the past 4 years our recommended update factor for PPS hospitals has been 1.5 to 2.6 percent less than the estimated market basket increase for that year. Therefore, while the Commission develops its recommendations with knowledge of the tight Federal budget, ProPAC does not specifically take the need to reduce the deficit into account. Recommendations from ProPAC represent the combined views of its Commissioners abut the appropriate changes in the system that will support a Medicare hospital payment system capable of providing access to high quality care at efficient levels of payment.

FUNCTIONING OF PPS

The prospective payment system sets a payment amount in advance for each patient who is hospitalized. These amounts are based on the use of diagnosis related groups, or DRGs. Each patient is assigned to one of about 475 DRGs based on the patient's diagnosis and in some cases the surgical procedure performed during the admission. Each DRG has a weight that indicates the relative costliness of the DRG compared with all others.

The payment to a hospital is determined by multiplying the DRG weight by a dollar figure called the standardized amount. Because hospitals in different geographical areas have different cost experiences, the Medicare program currently uses three different standardized amounts. There is one amount for rural hospitals, a second for urban hospitals in areas with more than a million people and a third for hospitals in other urban areas. The payment amounts are further adjusted by a wage index reflecting labor costs in the hospital's particular labor market area. Additional payment may be made to reflect added costs related to teaching interns and residents, added costs related to furnishing services to a high proportion of poor patients, and for cases with extremely high costs or long length of stay, called "outliers."

The three standardized amounts are updated each year to reflect several factors. First, the hospital market basket measures cost increases in the goods and services hospitals purchase. In addition, the law specifies that scientific and technologic advances that improve quality of care and hospital productivity should be considered. The update factor also is adjusted to reflect the mix and complexity of cases hospitals treat.

In recent years rural hospitals received higher updates than urban hospitals. And hospitals in large urban areas have received higher updates than other urban hospitals. In all cases, however, the debate concerning the level of the update factors, as well as many other changes, has been influenced by concerns related to the Federal deficit.

EFFECTS OF PPS AND OTHER CHANGES

Next, Mr. Chairman, I would like to briefly describe some of the effects of PPS on the Medicare program and on hospitals. The annual growth rate of Medicare spending for inpatient hospital services has slowed in the past 5 years. In fact in 1986 and 1987 there was actually a decrease in expenditures, when you remove the effects of inflation and control for the growth in the number of Medicare enrollees. Total Medicare expenditure growth has also declined from an annual rate of about 8% to an annual rate of about 4%. Again, these figures remove the effects of inflation and of growth in the Medicare population.

At the same time, however, the growth of services other than inpatient hospital care continues at very high annual rates.

The decrease in the rate of growth of hospital spending during the PPS years is due, in part, to the very significant decrease in hospital admissions. However, after significant declines just before and during the early years of PPS, hospital admissions began increasing again in 1985 and the following years. Admissions are now running at about a 2 percent per year increase, which is what one would expect from the increasing number of beneficiaries entering the Medicare program.

The decrease in the growth rate of Medicare spending is also due to the significant limits on Medicare payments to hospitals in recent years. In the early years of PPS, revenues greatly exceeded the rate of inflation as measured by the hospital market basket. Since then, however, revenue per case has grown only slightly faster than the market basket.

EXHIBIT I illustrates some of this important cost and payment information in terms of trends. As I mentioned earlier, each year hospital payments are updated to account for inflation and other factors. The hospital industry emphasizes that these updates have been consistently less than the rate of inflation.

While this is true, PPS increases in payments per case have always been substantially higher than the PPS updates, although this difference is less significant now than four years ago. Payments to hospitals have increased faster than the update factor because the payments automatically increase as the reported mix of patients across DRGs becomes more complex. As a result, the so-called hospital case-mix index (CMI) rises.

ProPAC's calculations indicate that for the first five years of PPS, hospitals received an increase of 11% in payments based on update factors and other policy changes, but additional payments of 21.5% from increases related to case-mix change.

In addition, Mr. Chairman, the Commission is also concerned about another important area that impacts dramatically on payments. EXHIBIT 1 also shows the large growth in hospital costs per case over the first four years of PPS. As you see, in the first year of PPS, Medicare cost per case increased on average 2.2%. Since then, however, costs per case have increased on average over 10% a year.

A frequently used measure of hospital financial condition is the hospital's margin or profit. The margin is calculated using hospital costs and revenues. During the first two years of PPS, Medicare payments to hospitals were quite generous compared to costs. As a result, most hospitals experienced very high margins or profits. This is shown in EXHIBIT 2.

All of this has changed in the past 3 years. Expenses have grown more rapidly than revenues and as a result, hospital margins are dropping.

ProPAC's analysis indicates that average first and second year PPS operating margins exceeded 14%. PPS margins fell to about 9% and then to 4.5% in the third and fourth years of PPS. We believe that the average PPS margin was about zero for fiscal year 1988, when hospitals began their fifth year on PPS. And while this is just an estimate, it is likely that the overall PPS margin for fiscal year 1989 will fall below zero.

The information I have just given you is based on average margins. Another concern, however, is that overall average margins mask significant variations at the individual hospital level. While some individual hospitals continue to have relatively high profits, others have had consistently low or negative margins. For some hospitals, these operating losses may jeopardize survival if they continue. Recently, in fact, an increasing number of hospitals have indeed closed.

Medicare's PPS is based on a system of averaging. Not all hospitals and patients are average, however. Recognizing these differences, PPS adjusts for many factors such as the complexity of cases, geographic location (urban or rural), labor costs, and other factors. Special adjustments are also mandated for costs associated with medical education and serving a significant number of low income patients.

The PPS statute recognized a long history of different costs in urban and rural hospitals by providing for separate urban and rural payment amounts. In the years following enactment of PPS, differences in the experiences of these types of hospitals led to decisions to provide separate update factors for urban and rural hospitals. More recently, a separate update factor has also been provided for hospitals in large urban areas with more than a million people.

Differential updates, however, are a very imprecise method of adjusting for differences among groups of hospitals. Therefore, there have been other legislative and administrative activities to refine payments to better reflect these differences. It is especially important in a constrained budget environment to examine the policies that determine how Medicare dollars are distributed among hospitals.

With this background, I will now describe ProPAC's recommendations for changes in PPS in fiscal year 1990. These recommendations are contained in our March 1, 1989 Report and Recommendations to the Secretary, Department of Health and Human Services. Further detail on our 17 recommendations is contained in the report itself, which is available from ProPAC's office.

Update Factor Recommendations

The Commission recommended an average increase in the level of PPS prices of 4.9 percent for fiscal year 1990, or about 0.8 percentage points below the projected market basket level of inflation. This average would consist of an increase of 5.0 percent for hospitals in large urban areas, 4.5 percent for hospitals in other urban areas, and 5.6 percent for rural hospitals. The table attached gives a full picture of our update factor recommendations (EXHIBIT 3).

As you see, the update factor recommendations combine several components. The largest is the PPS market basket. Last month, when we developed our recommendation, the market basket was forecasted to increase 5.7 percent in fiscal year 1990. Our recommendation also includes a positive adjustment, currently estimated at 0.6 percent, to correct for underestimates in the fiscal year 1989 market basket forecast. We have also recommended technical changes in the structure of the market basket. These technical changes give more weight to hospital industry wages than the market basket currently in effect. The changes thus address to some extent the costs hospitals are incurring in response to the shortage of nurses and other skilled personnel.

It is the Commission's opinion that any cost increase related to scientific and technological advancement should be offset by increases in hospital productivity. In other words, new and important technologies or procedures should be purchased by hospitals with money saved by encouraging improved productivity.

Therefore, we recommended a net 0 percent adjustment for these factors.

A negative net adjustment is recommended for case-mix change. This -0.7 percent adjustment is to offset the estimated added revenues that hospitals are receiving this year because of an increase in their DRG case-mix indexes that was not related to treating sicker patients. As I have indicated, we are very concerned about case-mix index change. Over the course of PPS, it has been a more important source of PPS revenue increases than formal annual updates in payment rates.

Our recommendation also includes a -0.8 percent reduction to the standardized amounts for urban hospitals. This reduction is the final portion of a three-year phased lowering of the rates that was previously recommended by the Commission. It accounts in part for the difference between actual first year PPS costs and the payment rates for that year. No reduction is applied to the rural standardized amounts because the reduction ProPAC originally recommended for rural hospitals has already been incorporated into the payment rates.

Finally, we have recommended a higher fiscal year 1990 PPS update for urban hospitals in MSAs with more than 1 million people. We have found that PPS accounts for most, but not all of the differences in costs between hospitals in large urban areas and other urban areas. We believe that research should continue to help us understand why costs are higher in hospitals in large urban areas, and we will continue to review this.

For hospitals and units excluded from PPS, we have recommended that the target rate of increase be determined separate from the PPS update factor. We believe that rehabilitation, psychiatric and long-term facilities' target rate of increase should be 6.2 percent for fiscal year 1990 based on current market basket estimates. This reflects the increase projected in these hospitals' market basket, including a correction factor for the fiscal year 1989 forecast error. We believe that the target rate of increase for children's hospitals should reflect the projected rate of increase for the PPS market basket, also corrected for forecast error, or 6.3 percent.

Other Adjustments to the Payment Formula

We have undertaken major studies of the indirect medical education adjustment and outlier payment policy. Analysis will continue in both of these important areas in the future.

For this year, ProPAC proposed to lower the adjustment to the PPS payment formula for indirect medical education from 7.7 percent to 6.6 percent. The Commission further recommended returning the savings to the standardized amounts for all hospitals, to make this change budget neutral.

Our analysis this year used third-year PPS Medicare Cost Report data to derive an empirical estimate of the relationship between teaching effort and Medicare cost per case. This study led to a teaching adjustment estimate of 4.4 percent. However, further analysis revealed that reduction of the medical education adjustment from the current level of 7.7 percent to 4.4 percent would have a dramatic effect on payments to major teaching hospitals. Concern about the overall impact of precipitously lowering payments to teaching hospitals led the Commission to recommend that for this year, only one-third of the total reduction implied by the current estimate of 4.4 percent be removed from the adjustment. Thus we have recommended a 6.6 percent adjustment for FY 1990.

Before proceeding with further reductions in the adjustment, the Commission believes that a careful reevaluation is necessary of the models, the analytical results, and the impact such changes have on the financial condition of teaching hospitals. The Commission will continue its work in this area. We will undertake a thorough analysis to examine the current and alternative methods for estimating the relationship between teaching effort and Medicare cost per case. We will also continue to assess the financial impact of lowering the medical education adjustment on teaching hospitals and hospitals that serve a high proportion of low income patients.

Other Important Issues

We are particularly concerned about data collection and management. We recommend several changes this year reflecting this priority. First, we strongly urge the Secretary to collect more current data on hospital wages and hours of employment, and to use these data to update the wage index for 1990. We believe that a permanent mechanism should be developed for obtaining accurate wage data, and that the index should be updated at least every other year. We continue to believe that the labor market areas, within which the wage index adjustments are applied, need to be refined. We also reiterate our belief that the Medicare Cost Report is a vital source of information, and we urge the Secretary to initiate developmental work that will facilitate further use of the cost report as a source of data for decision-making purposes.

Another important recommendation urges that the Secretary continue a comprehensive research and policy agenda to address financing and organizational issues of rural health care. This recommendation reflects the Commission's concern about the problems affecting rural hospitals and the rural health care system, as well as the implications of these problems for access to needed health care. The Commission recognizes, however, that these problems extend beyond PPS and Medicare. Of the multitude of pressures that rural hospitals face, only a portion are attributable to PPS.

The demographic and economic environment of rural communities is changing. An aging population, eroding patient base, and changing rural economy are among the forces influencing the long-term viability of rural hospitals. The Commission remains concerned about the relatively poor financial performance of rural hospitals under PPS, and will continue its analysis of rural hospital issues. The Commission will focus particularly on the appropriateness of PPS for small rural hospitals. Those hospitals are more vulnerable to wide fluctuations in volume and case mix than larger hospitals. Small rural hospitals have also generally had the lowest average Medicare operating margins over the first three years of PPS. Ten percent of rural hospitals with fewer than 50 beds have had PPS margins of -45 percent or lower.

Conclusion

At the end of five years, it is the view of the Commission that PPS has met many of its goals related to changing incentives for hospitals. The rate of growth in Medicare's inpatient expenditures has moderated. In recent years, however, hospital margins under PPS have fallen precipitously, partly because of large and unexpected cost increases. We have not found evidence of substantial or systematic changes in quality of care received by Medicare hospital patients since the implementation of PPS. Nor have we found evidence of a major reduction in the diffusion of new technology.

On the other hand, we have witnessed an increasing number of hospital closures. ProPAC is currently studying this trend. Our early findings indicate that prior to closure these hospitals tend to have fewer admissions and lower occupancy rates than other hospitals of similar size. To the extent that hospitals are closing because they are underutilized or have long-standing financial problems, closure may be appropriate, especially when there are other hospitals in the area. It is necessary, however, to carefully examine hospital closures and to maintain access to needed services for Medicare beneficiaries.

I hope that my testimony today is helpful to you. I have tried to describe some of ProPAC's analysis of PPS and the impact of the program and to explain our approach to changes for the program for fiscal year 1990.

I would be pleased to answer any questions you or the members of the Subcommittee may have at this time, Mr. Chairman.

EXHIBIT I

Cumulative PPS Cost and Payment Trends

Percent Change First Four Years

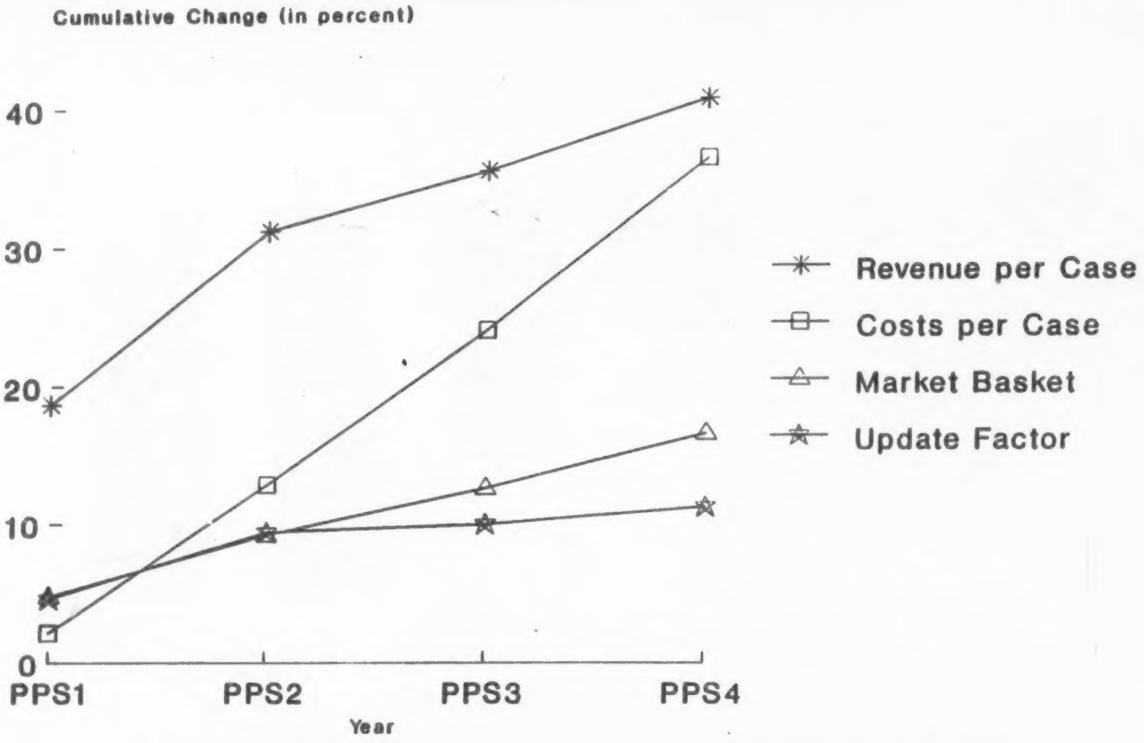

EXHIBIT II

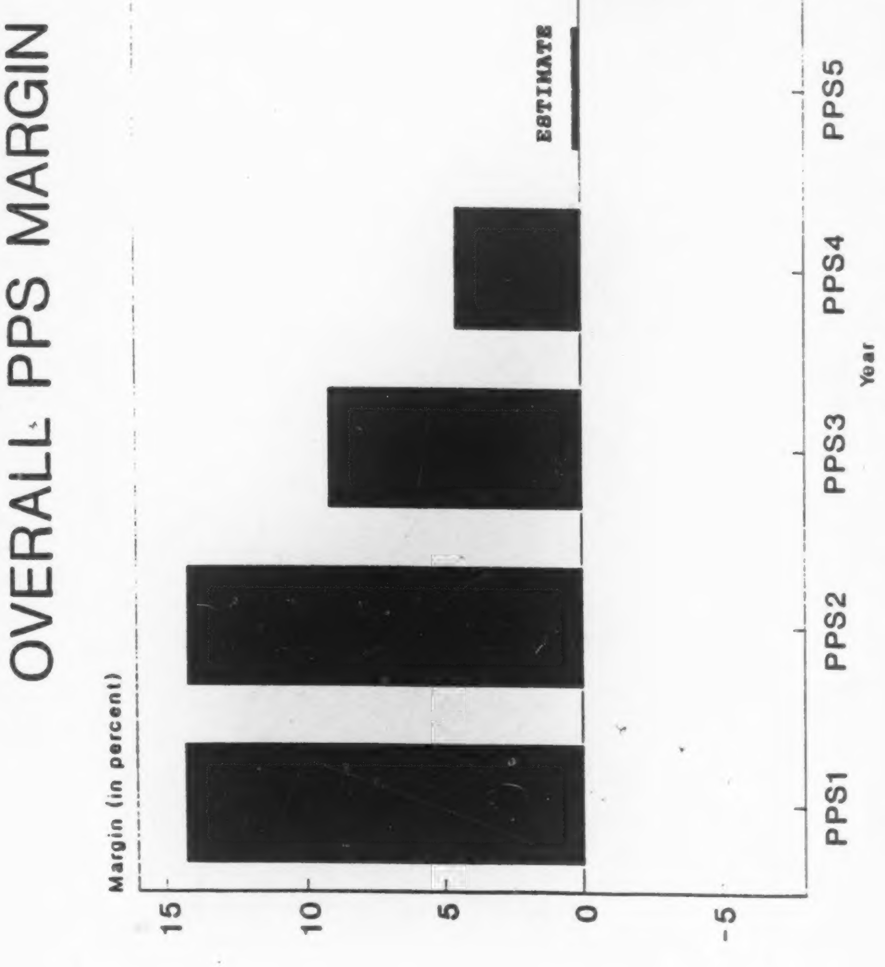
OVERALL PPS MARGIN
Margin (in percent)
15
10
5
0
-5
PPS1
PPS2
PPS3
PPS4
PPS5
PPS6
Year
ESTIMATE
??????

EXHIBIT III

Estimated PPS Update Factors for Fiscal Year 1990 Under ProPAC Recommendations

Total Update Factor	
Average update factor	4.9%
Large urban	5.0
Other urban	4.5
Rural	5.6
Components of the Update Factor	
Components applied to all hospitals:	
Fiscal year 1990 market basket forecast[a]	5.7%
Correction for fiscal year 1989 forecast error[b]	0.6
Components of discretionary adjustment factor	
Scientific and technological advancement[c]	--
Productivity[c]	--
Total discretionary adjustment factor	0.0
Case-mix change	
Total DRG case-mix index change	-3.0
Real DRG case-mix index change	1.5
Within-DRG patient complexity	0.8
Net adjustment for case-mix change	-0.7
Components applied to urban hospitals only:	
Third-year phased reduction to standardized amounts	
Adjustment for large urban areas	-0.8
Adjustment for other urban areas	-0.8
Urban population differential	
Adjustment for large urban areas	0.2
Adjustment for other urban areas	-0.3

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[a] Forecast of ProPAC-recommended PPS market basket by Data Resources, Inc.

[b] The market basket forecast used for the fiscal year 1989 update was 5.4 percent. The most recent fiscal year 1989 forecast is 6.1 percent. The full difference is not adjusted because no correction is made for errors in forecasting hospital industry wages.

[c] In the Commission's judgment, the added costs for scientific and technological advancement should be funded by increases in hospital productivity. Therefore, these components of the update factor sum to zero.

Chairman SASSER. We will turn to Dr. Ginsburg now, if he has caught his breath. We will be pleased to hear from you, doctor.

STATEMENT OF DR. PAUL B. GINSBURG, EXECUTIVE DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION

Dr. GINSBURG. Mr. Chairman, I am pleased to appear before you to provide background to the committee on the major physician payment issues facing the 101st Congress.

Chairman SASSER. Could you pull that microphone just a wee bit closer?

Dr. GINSBURG. These issues are being discussed very actively within the Commission. Indeed, major decisions on this year's recommendation to Congress are going to be made over the next 2 days. But because the decisions have not been made yet, my remarks should not be interpreted as conveying these decisions.

There has been very rapid growth in medicare outlays for physicians services over many years, and this has been the main motivation for congressional consideration of policy changes in this area. From 1980 to 1988, spending for physician services increased by 15 percent per year and, as you mentioned, Mr. Chairman, CBO projects continued high rates of growth in this program. In fact, the CBO projection for the physician component of part B is roughly double their projection of the growth in the gross national product.

Now, the key to these increases in outlays has been the increase in the volume of services per enrollee. We estimate that there has been about a 7-percent per year increase in the volume of physicians' services per enrollee in the medicare program. At this rate, services per enrollee double every 10 years.

Now, some of these additional services, no doubt, extend life and increase the quality of life for patients, but clearly some of these services do not benefit patients—or even harm them.

I want to mention some points about recent Federal policy. Congress has written legislation on medicare physician payment each year now since 1984, and there is a broad pattern of this policy. For one thing, there have been changes in the pattern of payments. The legislation has favored evaluation and management services, such as office visits, over technical procedures. Also, these policies have served to reduce some of the very wide geographic variation in what medicare pays for services.

Also, the issue of balance billing has been addressed by Congress. These are bills over and above what medicare approves for payments. Congress has established the participating physician program and also established a series of charge limits, which limit what physicians can charge beneficiaries above what the program approves.

A third element of Federal policy has been creating an infrastructure for further policy change. Congress mandated a relative value study to be conducted by the Secretary, and this resulted in the study that many are familiar with by Prof. William Hsiao at Harvard University. And Congress also created the Physician Payment Review Commission to advise it on reform and methods of medicare payment of physicians.

I would like to discuss the three most important policy issues, which are the fee schedule, effectiveness research and practice guidelines, and expenditure targets.

A fee schedule is seen as a device to bring about a very extensive change in the pattern of relative payments, and my full statement discusses some of the evidence that we have for the distortion of the relative payments among different services and procedures, and also concerning the very erratic pattern of geographic variation that we have now.

A fee schedule is advocated by many, including the Commission, because it would provide physicians a more suitable set of incentives as to how to practice medicine, where to locate, and what specialty to train for, and also would promote a more equitable system of payments among physicians and beneficiaries.

In addition, there are administrative considerations that argue for a fee schedule. The medicare physician payment system is a highly complex one, not understood well by either physicians or beneficiaries. A fee schedule would be a much simpler and easier to understand method of payment.

Now, let me review where we are in the process of developing a fee schedule. A fee schedule has been a goal of the Commission ever since its beginning somewhat over 2 years ago. At present, we are working very closely with the results from the first phase of the Hsiao study, and the Commission has been evaluating these results very carefully in specifying what areas need revision and, indeed, making some of the revisions on its own. The Commission has focused its efforts on the specification of how practice costs are to be incorporated into the relative value scale, on developing relative values for some of the specific evaluation and management services, such as office or hospital visits, and also on developing a uniform global fee concept for surgery to use as part of the fee schedule.

In addition to the work with the Hsiao study on the relative value scale, the Commission has been developing geographic multipliers to be used with the fee schedule, based in part on HCFA's work to develop a cost of practice index.

Finally, the Commission will be developing a policy on assignment and balance billing under the fee schedule. Enacting a fee schedule does require a new look at this issue, because some of the current policies on assignment and balance billing would not be applicable under a fee schedule. We have heard a range of opinions, from no restrictions at all on balance billings to mandatory assignment, and the Commission is focusing on options in between those ends.

Besides the fee schedule, the Commission is also concentrating on ways to slow the growth in the volume of services. This is the real crux of the budget problem in the medicare program. There are two policy directions in this area that the Commission is pursuing.

One involves effectiveness research and practice guidelines. Basically, physicians need better information in their practices on which services are appropriate and effective. If physicians had better information, they could improve the quality of care, and, at the same time, reduce costs.

The Commission is likely to recommend that the Federal Government support and direct the efforts of specialty societies, academic researchers and others to develop practice guidelines and to disseminate this information to practicing physicians.

The other policy to deal with the growth in volume is expenditure targets. A system of expenditure targets would provide a collective incentive to physicians to reduce the use of inappropriate services. In brief, the way they would work is that for a given geographic area, there would be a target rate of increase in expenditures per enrollee, and after comparing the actual experience with this target, fee levels would be adjusted in the subsequent year.

We envision that physicians would respond constructively to these collective incentives and the tools they would use would include the development and dissemination of practice guidelines and more vigorous involvement in carrier and PRO utilization review.

Overall, the expenditure target idea favors physician directed attempts to reduce costs through reducing inappropriate services.

I have a few comments about the 1990 budget. One of the problems that Congress is going to face is that these major policy directions that I have discussed do not seem to offer large short-term budget savings. Ultimate budget savings from a fee schedule would result from changes in patterns of practice and patterns of specialization, but these results are uncertain and long-term.

Clearly, savings could be accomplished under a fee schedule through the conversion factor. A conversion factor, although we have discussed it as budget neutral, could always be set at a lower level than budget neutrality. However, it should be clear that this is really similar to using other policies without a fee schedule to cut the prices paid for physicians services. If price reductions are going to be a part of meeting a budget target in medicare, they could be put into effect either through adjusting a fee schedule's conversion factor or else through pursing some of the policies that have been pursued over the last few years, in the absence of a fee schedule.

Practice guidelines and effectiveness research are likely to have a budget impact after a few years, but it is very difficult to project with precision when the savings would come or what their magnitude would be.

Concerning expenditure targets, an expenditure target system could begin quite soon, but it is not advisable to have a very tight target initially. The key to the success of expenditure targets is to allow time for physicians, carriers, and PRO's to develop the infrastructure to have a constructive response. So, I see expenditure targets as more of a medium-term budget option than a short-term one.

In conclusion, a policy direction towards medicare physician payment has been emerging over the past few years. This policy direction includes significant changes in the pattern of relative payments, additional limitations on balance billing, and the need to focus on slowing the growth in volume. The last area, focusing on slowing of growth and volume, is perhaps the most recent issue that has arisen and has not gotten attention for as long as the issues of relative payment and balance billing.

The key policies to be considered in this area are going to be effectiveness research and practice guidelines and expenditure targets. Will these policies be adequate to slow the rate of growth of medicare costs sufficiently? That is something we do not know at this point. If not, we may have to start considering approaches that go beyond those that are specific to the medicare program.

Mr. Chairman, I would be pleased to answer the committee's questions.

Chairman SASER. Thank you very much, Dr. Ginsburg.

[The prepared statement of Dr. Ginsburg follows:]

Statement of the

Physician Payment Review Commission

Before the

Committee on the Budget
United States Senate

Paul B. Ginsburg, Ph.D.
Executive Director
March 8, 1989

The Physician Payment Review Commission was created in 1986 to advise the Congress on reforms in Medicare physician payment. Its recommendations to date have guided the initial steps towards reform that the Congress has taken to date. Tomorrow, the Commission will be meeting to draft its 1989 recommendations to Congress, which are likely to include a cost-based fee schedule and a strategy to slow the growth in the volume of services through reductions in care that is inappropriate.

In my statement today, I plan to discuss the major options in physician payment policy that the 101st Congress is likely to consider. I begin with the factor motivating change--the rapidly rising costs of Part B of Medicare. Then I review the important policy changes that have been made in annual budget reconciliation legislation beginning in 1984. The core of the statement is devoted to a discussion of fee schedules, practice guidelines, and expenditure targets.

RISING COSTS

Outlays for Part B of Medicare have been growing at rates far exceeding reasonable benchmarks, with little relief in sight. From 1980 to 1988, outlays for physicians' services increased at an annual rate of 15 percent, more than tripling over the eight-year period.[1] This growth has led to the program becoming a more significant portion of the federal budget, so that continuation of this rapid growth has more serious implications than in the past. But CBO projects 13 percent per year increases for physicians' services over the next few years, roughly double its projection of increases in the Gross National Product.

The key factor behind this growth has not been price increases, which have been constrained by Medicare for some time, or enrollment growth, which has averaged about 2 percent per year, but increases in the volume of services per enrollee. The Commission and others have estimated that Part B services per enrollee have increased at about 7 percent per year. This means a doubling of services every 10 years. While some of these increased services have no doubt extended life and/or increased its quality, others have undoubtedly not benefited patients significantly or even harmed them.

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[1] Physicians' services account for about 75 percent of Part B outlays. Total Part B outlays increased at an annual rate of 16 percent, and totaled 33.7 billion in 1988.

RECENT FEDERAL POLICY

Almost 20 years elapsed between the compromises that led to the last-minute creation of Part B of the Medicare program and the beginning of a serious focus on reform of its mechanism for paying physicians. But starting in 1984, four successive years of legislation have established a direction for change and provided for development of the infrastructure to accomplish it.

Following its approach regarding hospital payment in the Medicare program, the federal government has addressed physician payment from the perspective of a large purchaser. It has been driven in large part by budget needs but has also given careful attention to the interests of major constituent groups--beneficiaries and physicians. While little consideration has been given to the interests of other payers, the fact that Medicare is less dominant a purchaser of physician services than of hospital services has led to more cautious approaches. Policymakers know that the degree to which private payers follow Medicare initiatives will affect the magnitude of reform that can be attempted, so consideration of attracting others to emulate new payment patterns will get increasing attention.

Frequent use of the budget reconciliation process has led Congress to write four major pieces of legislation since 1984 that have dealt with physician payment policy in the Medicare program.[2] Rather than trace the evolution of policy year by year, I will describe the total change in policy over the entire 1984-1987 period.[3]

For those not familiar with methods used by Medicare to determine payments to physicians, the essence of "customary, prevailing, and reasonable" (CPR) payment is to pay physicians what they charge, subject to two screens. The customary charge screen compares a physician's submitted charge for a particular service to what the physician customarily charged during the previous year. The prevailing charge screen for the service is the

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[2] In addition to budget reconciliation legislation, Congress wrote some provisions affecting physician payment in the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647).

[3] The specific provisions of each law are described in Congressional Research Service, Medicare: Physician Payment, Washington, DC, February 8, 1988.

75th percentile of customary charges of physicians (often in a particular specialty) in the locality. Since 1975, the rate of increase of prevailing charge screens has been constrained by the Medicare Economic Index, which tracks increases in practice costs.

Since 1984, policy has focused on three principal areas: changes in payment rates, limitations on balance billing (amounts charged by physicians in excess of the Medicare approved charge), and creation of an infrastructure for further policy change. With policy being budget driven, it should not be surprising that payment rates have been held back. This began with a 1984 freeze in Medicare payment rates and evolved toward annual increases that were smaller than previous formulas would have permitted. With the exception of the freeze, however, all of the payment limitations applied only to prevailing charge screens, so that physicians whose charges were below the levels of these screens were not affected.

More significant was the selectivity of payment constraint. Specific services were singled out for substantial payment reduction because they were considered overvalued by Medicare relative to other services.[4] Primary care services (defined as office visits, nursing home visits, home visit, emergency room visits) were exempted from additional payment constraints applied to other services. A geographic dimension to policy was also introduced, so that reductions in overvalued procedures varied among localities according to how the prior prevailing charge in each area compared to the national mean for each procedure.

Significant limits were placed on physicians' abilities to charge patients the difference between the submitted charge and the amount allowed by Medicare. The 1984 freeze prohibited increases in fees charged to Medicare beneficiaries. It was replaced by a series of limits on charge increases (known as MAAC limits). The MAAC limits are complex, but revolve around a key number--115 percent of the prevailing charge. Physicians could raise charges up to this amount over four years, but for those charges exceeding that amount, annual increases are limited to one percent. A version of the MAAC limits was applied to those procedures identified as overvalued.

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[4] See Physician Payment Review Commission, Annual Report to Congress, Washington, DC, March 1988, Appendix 1, for a description of the methods by which these procedures were identified.

After a short transition, charges for these procedures are limited to 125 percent of the reduced prevailing charge levels.

Congress created the category "participating provider" to increase patients' opportunity to identify physicians who take assignment.[5] A physician or other provider could obtain this designation by agreeing to accept assignment on all Medicare claims. Participating physicians are not restricted by MAAC limits in the amount they can charge and have prevailing charge screens that are 5 percent higher than nonparticipating physicians. They also are listed in a directory that is published annually and distributed to beneficiaries.

Congress took two steps to develop the infrastructure to pursue further policy change. It mandated the Secretary of Health and Human Services to conduct a relative value study and make recommendations to Congress concerning a fee schedule based on the study. It also created the Physician Payment Review Commission (PPRC) and asked it to make annual recommendations concerning relative payments, assignment and balance billing, and increases in utilization of services over time.[6]

To summarize, policy thus far has had a clear and consistent direction. Relative payments for different services and across geographic areas are to depart from historical patterns. Physicians are to be encouraged to accept assignment and be subject to limits on balance bills when they do not. In contrast to relative payments and balance billing, however, no direction has been set as to how to slow the increasing rate of utilization of services in Medicare.

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[5] Assignment means that the beneficiary assigns his or her right to payment by Medicare to the physician. In order to be is paid directly by Medicare, the physician agrees not to collect from the patient any more than applicable deductibles and coinsurance.

[6] Many of the policy changes described above were consistent with the recommendations of the Commission. These include reductions in prevailing charges for overvalued procedures, increases in payment for primary care services, and a payment increment for services delivered in health manpower shortage areas.

A MEDICARE FEE SCHEDULE

The 101st Congress is likely to seriously consider a fee schedule for Medicare. A fee schedule, which specifies either the amount to be paid or the maximum that can be paid for each service, would replace the current method by which submitted charges are screened for reasonableness.

Rationale for a Fee Schedule

A fee schedule would have three major components--a relative value scale (RVS), geographic and (possibly) specialty multipliers, and a conversion factor. The RVS establishes what each service or procedure will be paid relative to others. The same relative value scale would likely be used in all localities, but payments would vary from one geographic area to another, perhaps on the basis of a geographic index of practice costs. A conversion factor translates the relative values, altered by multipliers, into dollar amounts of payment. The conversion factor could be set to pay in the aggregate the same amount to physicians as before, or more or less.

A fee schedule would accomplish a number of objectives. Perhaps most important, it would provide a mechanism for wholesale revision of the pattern of relative payments. Many regard the current pattern of payments as significantly distorted from what a hypothetical perfect market would produce. The extensive but uneven use of health insurance and the difficulty of patients who are worried and in too much pain to act as rational consumers precludes market forces driving price down to marginal costs. Empirical evidence for the magnitude of the distortions comes from the recent relative value study by William Hsiao and his colleagues and from analysis of geographic variation in fees conducted by the Physician Payment Review Commission.[7]

A fee schedule that moved the pattern of relative payments closer to that of a hypothetical perfect market would provide a more suitable set of incentives to physicians and would improve equity among physicians. While financial incentives are certainly not the prime determinant of practice decisions by physicians, many suspect that they are relevant, for example at the margin of devoting additional time to history and physical examination versus performing diagnostic tests. Financial incentives might also affect decisions concerning specialty choice and practice location.

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[7] William Hsiao, Peter Braun, et al, "Results and Policy Implications of the Resource-Based Relative-Value Study," New England Journal of Medicine, 1988; 319:881-88.

Many physicians regard the differences across procedures in revenues per unit of time to be too large to be justified on the basis of differences in intensity of effort and required training. For example, the Hsiao study estimates that a general surgeon spends 3.4 times as long performing a gall bladder operation than performing a comprehensive office visit and devotes 1.8 times as much work per minute, but is paid 24 times as much by Medicare.[8]

Likewise, much of the geographic variation in fees cannot be justified on the basis of variation in costs of practice, whether defined narrowly, to include only overhead, or broadly, to also reflect varying opportunity costs of the physician input. Unexplained geographic variation is most striking when comparing charges for specific services in similar areas. For example, the 1984 prevailing charge for total hip replacement in Washington, D.C. was $1,547 compared to $4,126 in New York City, while the respective prevailing charges for a comprehensive office visit were $83 and $72. In an environment of continuing payment and charge constraint by Medicare, these issues of equity are taking on greater importance.

A fee schedule is more than a device to realign relative values, however. Administratively, it is a much simpler and less cumbersome method of determining payment rates. A fee schedule would end the need for maintaining fee profiles for each physician for each service and of calculating prevailing charge screens. It would facilitate many policies to more tightly manage the payment system, such as a precise and uniform definition of what services are included in global fees for surgery and other procedures. Politically, it could facilitate dialogue and agreements between the federal government and the medical profession.

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[8] William C. Hsiao, Peter Braun, et al, A National Study of Resource-Based Relative Values for Physician Services: Final Report. HCFA Contract 17-C-98795/1-03, September 27, 1988, Tables 64, 90, 91. Note that the time and effort for gall bladder surgery includes all services by the surgeon while the patient is in the hospital but does not include post-operative office visits.

Needless to say, a fee schedule has detractors, who raise a number of important objections. There is some question whether the perceived benefits are large enough to justify the degree of change and redistribution involved.[9] Others are concerned that Medicare beneficiaries would lose access to care as a result of Medicare payments diverging from current patterns followed by private payers. This will depend both on the degree to which private payers follow Medicare's lead and on the degree of sensitivity of markets for physicians' services to differences in payment rates. Still others worry about whether physicians will react to the altered relative prices in ways that are contradictory to the goals of the fee schedule. Economists cannot agree whether, at least in the short run, physicians will increase or decrease the volume of those services for which payments are reduced.

Indeed, the nature of the current market for physicians' services is critical to the potential of a fee schedule. If markets corresponded closely to the textbook ideal, few would see the need for a fee schedule that changes the pattern of relative payments. Most feel that physician services markets do not follow the ideal very closely, but our knowledge of how they actually do function is very limited. Research has been very difficult because of both limited data on physician services and the lack of natural experimentation in physician payment in the United States.[10]

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[9] William L. Roper, "Perspectives on Physician-Payment Reform: The Resource-Based Relative-Value Scale in Context," New England Journal of Medicine, 1988; 319:865-67.

[10] In the United States, research by Thomas Rice and Nelda McCall on the Colorado Medicare carrier's experience in consolidating eight charge localities into a single one (Changes in Medicare Reimbursement in Colorado: Impact on Physicians' Economic Behavior," Health Care Financing Review, vol. 3 (June 1982), pp. 67-86) is one of the few examples. Canada holds great promise for such research as each province has independently changed its relative value scale over time, thus providing both cross-sectional and time series variation. A research group at McMaster University is beginning one such project.

Developing a Fee Schedule

As noted above, the seeds for the development of a fee schedule for Medicare have been planted for some time. Congress mandated a relative value study by the Administration, created the PPRC, and mandated that it develop recommendations on relative payment issues. PPRC in 1988 recommended a fee schedule with a relative value scale based primarily on resource costs and outlined how it would develop a detailed proposal in its 1989 report to Congress.

The Relative Value Scale. In September 1988, William Hsiao completed the first phase of the mandated study for the Administration and published a relative value scale for 18 specialties.[11] Hsiao defined a concept of "work" that encompassed the time, mental effort and judgement, technical skill and physical effort, and stress involved in a service or procedure and surveyed practicing physicians to have them rate the work involved in various procedures. His relative value scale differs substantially from the pattern of current charges, with evaluation and management (EM) services valued more highly and technical procedures valued less.

The PPRC is using the Hsiao scale as a starting point in its work to develop a fee schedule proposal for Congress. It is evaluating the study carefully and conducting an extensive process of getting comments from groups representing physicians, beneficiaries, insurers, and other interested parties. The evaluation covers a wide scope, including assessment of the validity of the results from both a methodological and clinical perspective, simulation of the impacts of a Medicare fee schedule based on this RVS on physicians and beneficiaries, and modifications to the RVS.

At this point, PPRC envisions modifications in at least three major areas. First, the formula by which practice costs are incorporated into the relative value scale needs to be revised. In the original Hsiao formulation, estimates of the relative work by the physician affected not only the component of the fee that rewards the physician for time and effort but also the component that covers practice costs. This inadvertently magnified by a substantial margin the degree of change from current relative values. For example, a preliminary RVS developed by the Commission that is based on the Hsiao study has coronary artery bypass graft surgery fees declining 33 percent, in contrast to the 66 percent decline reported by Hsiao.[12] The reduction for cataract surgery would be 24 percent instead of 56 percent.

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[11] William C. Hsiao, Peter Braun, et al, "Results and Policy Implications of the Resource-Based Relative-Value Study". For a much more detailed description of the methods and results, see the nine articles published by Hsiao and his colleagues in Journal of the American Medical Association, vol 260 (October 28, 1988).

PPRC is also attempting to develop a formulation in which practice costs are aggregated by broad type of service (eg office visit, hospital invasive procedure) rather than by specialty. Besides the potential of greater accuracy, such an approach would decrease rather than increase the emphasis on specialty differentials.

The second area for revision concerns relative work values among EM services (visits and consultations). Coding for EM services tends to be much less precise than for surgery or technical services. Physicians within and across specialties interpret visit codes differently and use them to represent services that are heterogeneous in terms of time and work. Thus, any vignette in the Hsiao study is not likely to be representative of a particular visit code. Although the Hsiao method stands a good chance of obtaining a reasonably accurate estimate of the relative time and effort between EM services in general and other types of services, it is unlikely to produce accurate relative values among EM services.

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[12] The Hsiao estimate is from William C. Hsiao, Peter Braun, et al, "Results, Potential Effects, and Implementation Issues of the Resource-Based Relative Value Scale," JAMA, vol 260 (16), October 28, 1988, p. 2434.

The change in the formulation of practice costs is not the only difference between the PPRC and Hsiao scales, but it is by far the most important. Other differences include PPRC having taken account of changes in payment rates between 1986 and 1988 and extrapolation to a much larger number of services. Additional revisions are planned by the PPRC over the next few months.

Data analysis by the Commission has indicated how poorly current codes for EM services reflect the differences in the resources expended by physicians.[13] This is especially true for the levels of service (for example, brief, limited, intermediate) that differentiate visits within each class of EM service (for example, new patient office visits). PPRC analysis of raw data from the Hsiao study suggests that time is more reliable than current levels of service in predicting work within a particular class of visits. A reform in the method of coding that would incorporate time in the definition of level of service would allow the development of more accurate values for EM services based on the estimated relationship between work and time. The Commission is considering such reforms and is developing refined values for EM services using raw data from the Hsiao study and a new log-diary survey of physicians' visits and consultations.

The third area for additional work to the Hsiao RVS concerns definitions of global surgical fees. Traditionally, the fee for a surgical procedure has covered many operative procedures and postoperative care. The specifics of these policies vary from carrier to carrier, however, and avoiding double payment for services has been less than perfect. The Commission has used consensus panels to develop a standard definition of global fees for surgery. The estimates of relative values for surgery will have to be adjusted to reflect the new policy.

Medical specialty societies have also been studying the Hsiao RVS and have raised specific problems that affect the relative values for their specialty. Many of these appear to be valid and warrant attempts to correct them. The second phase of the Hsiao study will be able to deal with some of these, but additional methods, such as intraspecialty consensus panels, may be needed as well. The Commission is contemplating organizing such a process.

Other Aspects of the Fee Schedule. While the RVS has gotten most of the attention of the media to date, other components of the fee schedule are likely to be equally, if not more, controversial. Geographic multipliers and policies on assignment and balance billing are the most important. The concept behind the RVS--that costs should determine relative payments--applies to geographic variation as well. It often seems that every physician is aware of colleagues in other localities that get paid more than they do for a particular procedure without the difference being justified on the basis of practice costs--and has complained to his congressman about it. Members representing rural areas tend to have a particularly strong interest in reforming the pattern of geographic variation.

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[13] Presentation by Roz Lasker, M.D. to the PPRC, November 9, 1988.

Many fee schedule advocates agree that geographic multipliers should reflect a geographic cost-of-practice index. The Urban Institute has developed a variety of preliminary indexes for HCFA and is refining them.[14] What should be included in the index is subject to debate. While most agree that differences in the prices of office space and nurses' wages should be reflected in payments to physicians, debate continues on whether payment for the opportunity cost of the physician's time should vary.[15] In a hypothetical perfect market, payments to physicians for the opportunity costs of their time would vary on the basis of what it would take to get a sufficient number to locate in an area. This concept could be approached by using an index of earnings of nonphysicians. But others assert that equitable payment would require uniform valuation of the physician input.

Consideration of a fee schedule is also directing attention to policies on assignment and balance billing. The American Association of Retired Persons has stated that once the payment structure is rationalized, that assignment should be mandatory.[16] The American Medical Association continues to emphasize its strong opposition.[17] If one looks at recent federal legislation, a potential middle ground option is apparent. Recent policy has encouraged voluntary assignment through the participating provider category but also has place direct limits on the size of balance bills. For example, 1987 legislation developed a fee schedule for services provided by radiologists.[18] After a transition, charges for these services will be limited to 115 percent of the fee schedule amount.[19]

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[14] Stephen Zuckerman and W.P. Welch, "The Development of an Interim Geographic Medicare Economic Index," The Urban Institute, Center for Health Policy Research, December, 1987.

[15] Some organizations, such as the American Academy of Family Physicians, have advocated uniform national fees.

[16] Statement of Marilyn Moon, Ph.D. before the Physician Payment Review Commission, November 8, 1988.

[17] Statement of Alan Nelson, M.D. to the Physician Payment Review Commission, November 8, 1988.

SLOWING GROWTH IN VOLUME OF SERVICES

Medicare outlays for physicians' services have grown very rapidly in recent years. From 1975 to 1986, outlays grew at nearly an 18 percent annual rate. An important part of this growth has reflected increased volume of services per enrollee, which grew 8.5% percent annually between 1980 and 1985. Volume growth captured the attention of the general public in September 1987 when the Part B premium was increased by 39 percent.

While the premium increase generated a great deal of "finger pointing" concerning the role of physician versus beneficiary decisions in the rising volume of services, most accept the need for constraint. Most also agree that no matter what the long-run potential of capitation in Medicare, some success in constraining volume of services under fee for service is essential. Most policy attention is likely to be focused on two options--one involving effectiveness research and practice guidelines and the other using expenditure targets.

Effectiveness Research and Practice Guidelines

Recent research has suggested that substantial amounts of ineffective care is delivered because of lack of knowledge by physicians as to the risks and benefits of procedures. In some cases, research evaluating effectiveness or optimal uses of a procedure simply does not exist. Wennberg attributes much of the small area variation that he finds to local norms remaining distinct because of the absence of research results suggesting optimal treatment.[20] In other cases, the results have not been sufficiently disseminated to practicing physicians. The recent studies by Brook and Chassin, in which leading physicians have developed a consensus as to what are the appropriate indications for use of a procedure, document substantial use of services that are "clearly inappropriate".[21]

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[18] Public Law 100-203, The Omnibus Budget Reconciliation Act of 1987.

[19] Since the initial payment rates were set at 97 percent of the fee schedule amount, the limit on balance bills is actually 18 percent of the amount approved by Medicare.

During the last 2-3 years, increased resources have begun to be committed to research on effectiveness. Congress has authorized the National Center for Health Services Research to make grants for research on "outcomes" and provided some funding. The Health Care Financing Administration has begun to organize its vast claims databases to support research on effectiveness by intramural and extramural scholars.[22] Major issues over the next two years concern the level of federal resources that are to be committed to these and other efforts to increase our knowledge of effectiveness and the structural framework for these activities.

Development and dissemination of practice guidelines is being pursued to provide the practicing physician access to the results of effectiveness research. To date a number of medical specialty societies have developed practice guidelines, with the American College of Physicians the most active. In addition, researchers at the RAND Corporation have developed guidelines in the course of conducting research on variation in use of services. Recently, the American Medical Association announced a major effort with the RAND Corporation to develop practice "parameters". Practice guidelines or parameters can affect patterns of use of services both through the provision of educational material to physicians and through the development of sound criteria for utilization review.

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[20] Wennberg, J.E., "The paradox of appropriate care," Journal of the American Medical Association 258(18):2568-2569, 1987.

[21] Chassin, M.R., J. Kosecoff, et al. "Does inappropriate use explain geographic variations in the use of health care services?" Journal of the American Medical Association, 258:2533-2537, 1987. In these studies, inappropriate connotes that medical risks exceed medical benefits for that patient.

[22] William L. Roper, William Winkenwerder, et al, "Effectiveness in Health Care: An Initiative to Evaluate and Improve Medical Practice," New England Journal of Medicine, vol. 319 (November 3, 1988), pp. 1197-1202.

A policy issue before the federal government now is whether to use public funds to increase the magnitude of efforts in this area. Few would advocate that the government develop the guidelines itself, but it could support efforts by medical societies and private researchers to do so. Along with funding, the federal government could participate in setting priorities and improving the techniques for development and dissemination.

Needless to say, the relationship between guideline development and cost containment is uncertain. A practice guideline might help to eliminate inappropriate care and save the costs of such care, but in other instances it might increase the intensity of services used for diagnosis and treatment by apprising the practicing physician of additional effective procedures. While the appropriateness and quality of care would increase, costs might increase as well. In addition, experience of previous efforts to use education to affect practice behavior has been decidedly mixed.[23] This has led many to maintain that incorporation of guidelines into utilization review criteria would be essential for success.

Expenditure Targets

Expenditure targets would provide a collective incentive to physicians in an area to contain the volume of services delivered to Medicare patients. For a defined geographic area, a target of expenditures per Medicare enrollee would be established on the basis of area spending in a base year and a target rate of increase. Comparison of target spending with actual spending would lead to positive or negative performance adjustments to be applied to the following year's payments.

While expenditure targets would use financial incentives to change physician behavior, the incentives would not be directed to the individual physician, but instead to area physicians collectively. If targets were to have their desired effects, physicians would need to organize themselves to contain costs. Collective activities could include additional development and dissemination of practice guidelines by physician organizations and others, additional participation by practicing physicians in the work of peer review organizations, and even more frequent reporting of peers' fraud and abuse to carriers. Physician organizations might even revise their current views on additional policy options to control costs, since they would be sharing responsibility for cost containment with beneficiaries and taxpayers.[24]

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[23] Eisenberg, J.M., Doctors' Decisions and the Cost of Medical Care, Health Administration Press, Ann Arbor, MI, 1986.

An important part of an expenditure target policy would be opportunities for individual physicians to opt out of the area-wide target by joining a smaller group of physicians that is placed at risk for its practice decisions. Such opportunities could include both those currently existing for HMO risk contracts with Medicare and new ones involving looser organizations such as PPOs.

The key argument in favor of the expenditure target option is that it emphasizes physician-directed attempts to reduce costs through reducing inappropriate services. To the degree that physicians are successful in this endeavor, it would appear to be more acceptable to most affected parties than the apparent alternative of reductions in payment rates. Arguments against expenditure targets are that 1) they will be set too low (require a larger reduction in utilization than physicians can bring about in a fee-for-service context) in order to achieve large budget savings and 2) physicians will fail in collective attempts to respond to the incentives and the result will be sharp reductions in fees--reductions substantial enough to affect beneficiary access.

OPTIONS FOR THE 1990 BUDGET

If Congress decides to make substantial reductions in physician payment, it is likely to find that the major policies discussed above cannot be implemented soon enough to provide large budget savings for fiscal year 1990.

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[24] One example is pending legislation on physician ownership interests in facilities to which they refer patients. While many physician organizations have urged their members to avoid such arrangements on ethical grounds, they have not supported legislation to prohibit specific practices. They might take a different position in the context of expenditure targets.

While a Medicare fee schedule is not envisioned as a budget policy, its conversion factor could be set to reduce payments to physicians. But implementation before 1991 is unlikely. Increased support for effectiveness research and practice guidelines cannot be used as a near-term budget policy because 1) the supported activities will take time to develop and grow before they can affect practice in a substantial way and 2) it will be difficult to link projected activities with likely budget impacts. Expenditure targets could be implemented as early as 1990, but setting the targets so as to produce large budget savings in the first year could be problematic. The infrastructure by which physicians could respond constructively to expenditure targets will take time to build, and placing heavy demands on it before it is ready could jeopardize its long-term potential. Expenditure targets should be viewed more as a medium-term budget option than a short-term one, even if the policy were implemented soon.

Policy options to reduce the 1990 budget should be steps that move the program in the longer-term policy directions discussed above, or at least do not increase the difficulty of pursuing them. For example, the overvalued procedures and primary care provisions of the 1987 budget reconciliation legislation moved relative payments in the direction projected for a fee schedule. The Reagan budget has followed this course by proposing additional reductions for overvalued procedures, a reduction in payments for radiology and anesthesiology, and increases for primary care. Some in Congress have contemplated using the results to date from the Hsiao study to identify additional overvalued procedures. In addition, for high-volume services, prevailing charge screens in those localities which are far in excess of the national mean could be reduced.

A key political issue to be addressed will be whether these short-term budget policies increase or decrease the likelihood of enacting a fee schedule during this year. The likelihood could be increased by demonstrating once again the direction than Congress is taking. But substantial payment adjustments prior to a fee schedule could diminish support for a fee schedule by some, as a portion of its goal of rationalizing the payment structure would already have been accomplished. If such developments were to occur, the federal government would lose credibility for having pursued the fee schedule route and using all of the data produced only to reduce payments for selected services and areas.

An alternative that might resolve this dilemma would be an interim fee schedule. By limiting the number of procedures and applying percentage changes in payment rates to categories of procedures, a fee schedule could probably be implemented in 1990. If suitably designed, it could serve as the transitional phase for the full fee schedule, which would take effect a year or two later. I have suggested such an approach to the Commission within the past few days, and it will be discussed during the Commission meeting tomorrow.

CONCLUSION

Over the next two years, Congress will choose whether to accelerate the policy changes that it has put into effect since 1984. The policy direction on relative payments in Medicare is very clear. Thus far, payment reductions that are needed to meet budget objectives have been concentrated on those procedures and geographic areas thought to have charges that are high relative to costs. A continuation of this policy would involve combining increases for selected undervalued services with additional reductions for overvalued services and applying the policy to a greater number of services. A fee schedule would involve a more comprehensive approach to realigning relative payments. To date, the general policy direction has enjoyed substantial consensus.

Discussions regarding policies concerning assignment have been much more contentious. In the absence of consensus, the future course is more difficult to predict. Medicare now encourages assignment through the participating physician category and limits the size of balance bills through MAAC limits and through provisions applying to services of radiologists and services for which prevailing charges have been reduced. Major decisions concerning assignment are likely because inaction does not guarantee continuation of the status quo. If MAAC limits continue in their present form, they will constitute an increasingly stringent limit on balance bills over time. Either a fee schedule or simply an extension of overvalued procedures policy to more procedures will require a revision of MAAC rules because the 1984 base of actual charges will be less relevant.

Policies designed to deal with rapidly rising volume of physician services may constitute some of the most difficult decisions. Uncertainty concerning the effectiveness of various options is very high. Few are very confident that the solutions that they advocate will work. Emphasis on pursuing multiple approaches would be warranted.

The quandary over how to slow rising volume has led many to begin to think beyond Medicare policies. Many who advocate the competitive approach realize that further progress in enrolling the privately insured in competitive health plans might be needed before private health plans play a much larger role in Medicare. All-payer policies for physicians' services come up in discussions with increasing frequency. Some have a Canadian model in mind--physicians working collectively to deliver care under a budget constraint. Others see all-payer policies as a more serious spur to doctors to opt out of unmanaged fee for service by affiliating with competitive health plans.

Chairman SASSER. We have been joined by our colleagues, Senator Simon and Senator Grassley. Both advise me that they do not have any opening statements at this time, so I will go forward with some questions.

Dr. Ginsburg, you have outlined for us in your statement the rapid rise in the part B physicians' costs. Now, detail for us, if you will, the reasons for these increases?

Dr. GINSBURG. When you break down the increase in it, there are three major components. One is the growth in the number of enrollees. That has been about 2 percent per year, so that is not a major factor. Then you have price increases and——

Chairman SASSER. What did you say, that it was 16 percent a year for part B?

Dr. GINSBURG. That is for all of part B, right. The figures that I have in my testimony were just for the physician component of part B.

Chairman SASSER. And that was how much, 13 percent?

Dr. GINSBURG. That was 13 percent a year.

Chairman SASSER. All right, and 2 percent of that is patient growth?

Dr. GINSBURG. That is right. Another part of that is due to price increases, and in part B, I would say the medicare program has fairly firm control now over price increases. Medicare was designed to pay what physicians were charging patients, subject to screens, but in the mid 1970's medicare capped that. It limited growth in prevailing charge screens to a medicare economic index. Then, beginning in 1984, Congress further reduced increases in those screens by having smaller increases in the medicare economic index than would have happened otherwise.

Chairman SASSER. What were the components of the medicare economic index? In other words, this was a special way of measuring the rate of inflation in physicians' services, is that——

Dr. GINSBURG. It attempts to measure the increases in the costs of practice that physicians face. The index for the most part, even before the 1984 legislation, tended to increase more slowly than physicians' charges did. Thus, between 1975 to 1984, it became a more and more serious constraint on what medicare would pay physicians.

Then, in 1984 there was a freeze in both what medicare would pay physicians and what physicians could charge. So the price part has been controlled fairly tightly, especially in the past few years. This leads to the major cause of the increase in expenses growth in services per enrollee. When you think of the 7 percent a year increase, that is very large.

Chairman SASSER. Now, when you say "more services per enrolle," are we saying when we try to push down on the physicians' cost per procedure, are we saying the physician just enlarged the number of procedures that he carries out on an individual patient in order to keep the bill constant or growing? Is that what you are saying?

Dr. GINSBURG. Well, there may be an element of that; but, based on the data I have seen covering 1983 to 1986, that is not the major part.

Chairman SASSER. What is the major part of it?

Dr. GINSBURG. The major part is growth of certain new services. For example, cataract surgery has also grown very rapidly. Outpatient surgery in general has also grown very rapidly, and it does not appear to be a substitute for inpatient surgery. Much of the increase we have seen in outpatient surgery seems to be a net addition.

When we look at the rate of visits we do not see much change. Over this period hospital visits declined, probably due to reductions in admissions and lengths of stay and——

Chairman SASSER. And then we get excess capacity of the hospitals. We heard about that this morning.

Dr. GINSBURG. Yes, and office visits have increased, but total visits have remained about the same. So, whereas there might be some response by physicians to the pressure on fees that the program has put forward, I suspect that a lot of the volume increase is independent of that.

Chairman SASSER. Well, let me just follow up with you, Dr. Ginsburg, and ask you to describe how do we now pay physicians under medicare, and how does that system contribute to cost increases, if it does?

Dr. GINSBURG. We pay physicians on a fee for service basis. Fee-for-service payment of physicians has the incentive that when physicians do more, they get paid more. That is broadly accepted as one of the down sides of fee-for-service.

Chairman SASSER. One quick question for you, Mr. Steinwald. I take it from your testimony that the Commission agrees that overall hospital medicare operating margins are now close to zero, is that correct?

Mr. STEINWALD. Yes, sir. In fact, I think we can say safely that as of the present the average medicare margin is below zero.

Chairman SASSER. But there is still great disparity between hospitals. Some hospitals have large margins still, and others have been operating at a loss for some time, is that a fair characterization?

Mr. STEINWALD. That is also correct, Mr. Chairman. That is——

Chairman SASSER. Well, which hospitals are still more likely to have higher margins, and what is the reason for that?

Mr. STEINWALD. Well, there is no single reason. One of the important reasons relates to the historical patterns of costs and the variations in those historical patterns around the country.

We now have in place, after a 5-year transition, a national payment system that adjusts prices for the costs of the goods and services that hospitals purchase. It does not, however, adjust payments for historical patterns in practice that have varied from one part of the country to the other. Therefore, hospitals that are located in those parts of the country that have historically had a costly style of care are those that are most likely to be in financial difficulty, and that includes, for example, hospitals in the industrial cities of the central part of the United States, such as Chicago, Detroit, and Cleveland.

Now, there are variations even within those regions. Hospitals, for example, that are located in the suburban ring parts of metropolitan areas and not located in the inner city, where costs of service tends to be higher, tend to be better off. Because if you are located in a suburban ring of a metropolitan area, the chances are that many of your costs of doing business are lower than in the inner city, and yet our payment system does not yet reflect that variation in costliness.

Chairman SASSER. Well, I would like to have some follow-up questions on that, but my time is expired.

Do you wish to ask some questions, Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman.

I understand that we have seen increases in the overall part B medicare expenditures, despite our cost containment efforts directed at individual physicians and, of course, we have heard that this is attributable to increases in the use of hospital outpatient services and increases in utilization of individual physicians' services, so I believe it would be appropriate for you, Dr. Ginsburg, if you could suggest steps that Congress could take for the next budget cycle for appropriate responsible control of utilization of physician services and whether or not it is possible to make such recommendations in the absence of a capacity to determine the effectiveness or appropriateness of those services, assuming that you agree that we donot have that capacity.

Dr. GINSBURG. As you mentioned, Senator, the key to assessing the effectiveness and the appropriateness of services is the key to long-term success in controlling costs in the medicare program and for private payers of physicians' services as well.

There is some knowledge now on what services are effective and when they are appropriate. We need to have a lot more of that knowledge, and it is particularly important to get that process started as soon as possible. I doubt that people are going to be able to measure the budget payoff for 1990, but it really should be put into effect soon.

However, just dispensing the information will not be enough. There have to be incentives for physicians to use that information. The standard incentive would be utilization review processes. Through the peer review organizations and the carriers, the medicare program does pursue the review of utilization for its medical necessity.

The program is evolving. Many realize that we need to take a more comprehensive approach towards a complete episode of care for a patient, rather than just the individual claims. One of the virtues of the development of practice guidelines is to give the utilization reviewers criteria with which to review care more effectively and have it make more sense and seem more reasonable to the physicians that are being reviewed.

The other thing that the Commission has been discussing—and we will make a decision on whether to recommend it to Congress at our meeting tomorrow and Friday—is whether to use a further incentive of an expenditure target system which would provide a collective financial incentive to physicians, so that they would get all of their might and energy behind the development of practice guidelines and more effective utilization review.

Senator GRASSLEY. I thank you, Dr. Ginsburg.

I do not have any more questions, Mr. Chairman.

Chairman SASSER. Thank you, Senator Grassley.

Senator Simon?

Senator SIMON. Thank you, Mr. Chairman.

Mr. Steinwald, in your written statement here, I notice that you say, "For example, the 1984 prevailing charge for total hip replacement in Washington, D.C. was $1,547, compared to $4,126 in New York City." Is this still the case? Is this your statement, Dr. Ginsburg?

Dr. GINSBURG. Yes, that was my statement.

Senator SIMON. I am sorry.

Dr. GINSBURG. Yes, those numbers came from the 1984 medicare prevailing charge directory, and I see no reason why the pattern would be any different today. Prevailing charges have not changed much since 1984.

Senator SIMON. Obviously, the Budget Committee cannot get into the details of something like this, but one of the things we clearly need is some greater rationality in charges for services on the basis of geography.

Dr. GINSBURG. Yes, the Commission feels very strongly about that, and as part of its fee schedule proposal, is going to be proposing that we toss aside the current pattern of geographic variation and, instead, develop a geographic multiplier that reflects differences in the costs of practice in different areas and that would determine how fees should vary from one area to another. From the simulations that we have done it is very clear that the range of variation would be much smaller under these multipliers than we are experiencing at the present time.

Senator SIMON. I was in White Hall, IL llinois the night before last, a small community in Illinois that had a hospital, no longer has one. When I asked what caused the hospital to close, they said medicare and medicaid. If medicare and medicaid had paid the actual costs, that hospital would continue to exist.

We face a very tough decision here in what level of medicare assistance should be provided. I look through your fine statements, but I do not find any specific recommendation on where we should go. If you were a Senator from Nebraska or Tennessee or Illinois, what level would you favor for medicare payments?

Mr. STEINWALD. I think that one is mine, Senator Simon.

Earlier, I did say that the Commission had determined that it was appropriate to continue to update rural hospital payments at a higher level than urban hospital payments, as has been done over the past 2 years under prospective payment.

I did say as well that the Commission has on its agenda a continuation of an examination of specific issues related to medicare reimbursement of rural hospitals, such as the continuation of the urban-rural differential, such as whether certain isolated rural hospitals ought to be excluded from the prospective payment system, and an examination of rural hospital closures and the extent to which they jeopardize access of medicare beneficiaries.

But this year, the Commission was not persuaded by the evidence that it had before it that it was appropriate to make any specific recommendation of that kind, and in fact wanted to emphasize in its recommendations that it believes that the problems of rural hospitals are real and genuine and serious, but they cannot be seen as exclusively problems of medicare reimbursement.

A 40-bed hospital in a rural community that has an average daily census of 12 patients, which is not uncommon, will not have its problems solved by a higher medicare or medicaid reimbursement. So we have urged the Secretary to intensify his efforts to find more global strategies in addressing the problems of rural health care, not just the problems of rural hospitals per se, but the problems of rural health care delivery, that to some extent require some transition from health care that is hospital-oriented to health care that may be more extensive in its outlook and may focus less on hospitals and more on other kinds of services.

Senator SIMON. I do not want to exaggerate the rural hospital problem, because it is obviously not just rural hospitals that are facing this problem. If you take a look at the city of Chicago—and my guess is this is true of Omaha, NE and Nashville, TN, and any place else—the hospitals that are closing serve the poor. They are on the West Side of Chicago, they are on the South Side of Chicago.

I talked not too long ago with someone who faces the real major possibility of having to close three more hospitals in the city of Chicago. And while your Commission is not making any recommendation, Mr. Steinwald, let me just ask you personally, should we be cutting back to the tune of $5 billion in medicare—from the current services—from the anticipated expenditure? How would you vote if you were on this Budget Committee?

Mr. STEINWALD. Senator, the Commissioners that I serve submitted a set of recommendations on March 1 to the Secretary of Health and Human Services and to the Congress. Embodied in those recommendations are recommendations on up-dating payments and otherwise redistributing payments among hospitals.

The net effect of those recommendations would be a small saving from the base line, but nothing on the order of what the President's budget has proposed. It would be more on the order of, I think, $300 million. The Commission, however, does not see its job as budget-driven, principally because Congress did not specify its mandate as being one that should focus on the budget, but ProPac certainly makes decisions within an environment where Commissioners know that people like yourselves have to operate within a contained fiscal environment.

The Commission's recommendations and the financial implications of them, the Commissioners believe, are tough, but fair. But ProPac recommendations are nowhere near the savings generated as the President's budget would suggest.

Senator SIMON. I thank you.

Thank you, Mr. Chairman.

Chairman SASSER. Thank you, Senator Simon.

Senator Exon.

Senator EXON. Mr. Chairman, thank you very much.

Gentlemen, let me pursue that line of questioning, if I might. We did get into this, as indicated by the questions of previous Senators in this morning's testimony. As I understand one of the problems that we have today, generally the rate of occupancy of hospitals in general, bed-wise, is down considerably to what it was a few years ago. In other words, it is not uncommon to have the occupancy ratio on a bed basis down to the 40 to 60 percent range, is that correct?

Mr. **Steinwald**. It is not uncommon, yes, sir.

Senator **Exon**. And was not that quite uncommon 5 or 6 years ago?

Mr. **Steinwald**. That is correct. The decline in inpatient admissions began, I believe, in about 1983. Before that time, the average occupancy rate of hospitals was substantially higher than it is today.

Senator **Exon**. And we were quite proud of the fact not too many years ago, in fact when I was Governor of Nebraska or a short time thereafter, we had a government program that almost encouraged communities to build hospitals with pretty sizable grants, is that not accurate?

Mr. **Steinwald**. Yes, sir, I think it is fair to say that the entitlement program reimbursement policies encouraged hospitals to expand.

Senator **Exon**. And I think that not too long ago we were still on that rise, and I suspect that we had better be up-front and say that in recent times, because of the highly, vastly escalating costs of medical care, including premiums on medicine and the fact that the government was behind each and every year as to what they anticipated they would have to spend for this, that there has been an arresting of these people staying in the hospitals, you know, as a combination of actions by the Federal Government and by a change in attitude that indicates that we used to keep people in hospitals generally longer than we had to for the given ailment that they went in on. Is that correct?

Mr. **Steinwald**. Yes, sir, although I would not underestimate the effect of changes in clinical technology that Dr. Ginsburg referred to earlier. A prime example in that early in this decade almost all cataract surgery was performed in the hospital and lens implants were done in the hospital, and those are very, very common procedures under the medicare program.

Over the space of 3 to 4 years, nearly all of those cases have been moved out of the hospital and now are performed on an outpatient basis, and the principal reason for that is not related, I believe, to the reimbursement policy, but in fact to changes in medical technology.

Senator **Exon**. Doctor, give me a little more widespread—there are a lot of cataract operations, but I imagine they have more people in the hospital giving birth to babies than we do having cataracts. When did this turn-around start with regard to moving women out of hospitals much faster than they did? Is that in the last 5 years, or does it predate that?

Dr. **Ginsburg**. That has been a much slower change than was experienced in cataracts. With cataract surgery there was new technology that made the procedure safer and less painful, and cataracts are the number one procedure in medicare as far as expenses for physician payments. The volume of procedures is very large and the payments are very high, so that probably had a noticeable effect on what hospitals were doing.

Senator **Exon**. You seem to be skirting the issue that I am trying to get at. I do not know how many complaints we have had in our office from physicians that complain that they cannot take people into the hospital or they had to kick them out of the hospital, because of rules and regulations from the Federal Government. That must be the main reason that our hospitals are not over-used today. Is that not true?

Mr. **Steinwald**. I will start out and then let Dr. Ginsburg pick it up. We are both, I think, suggesting that technological change is as important as any other factor. It is, however, true that the prospective payment system that was instituted in fiscal 1984 did encourage hospitals to shorten their lengths of stay.

Senator **Exon**. You bet.

Mr. **Steinwald**. But the——

Senator **Exon**. That is all I need. I was just trying to get that fact established. My time is up and I thank you for finally coming to the answer that I thought was true, but I thought we should get it on the record.

Chairman **Sasser**. OK. Thank you, Senator Exon.

Mr. Steinwald, with regard to hospital closures, the American Hospital Association estimates that some 81 community hospitals closed last year. Do you agree with that number?

Mr. **Steinwald**. Mr. Chairman, I do not have a good reason to disagree with it. You may be aware that at a hearing last week before the House Ways and Means Committee, that figure was challenged by Chairman Stark of the Health Subcommittee. We ourselves, though, do not have a way of determining yet whether that figure is accurate.

We have initiated some study ourselves of hospital closures, as I mentioned before, and are prepared in our June report, which we issue every year, to present some statistics on hospital closures that will be principally descriptive.

But to get at the main issue of whether these closures represent a deterioration in access to needed services of medicare beneficiaries is a thornier issue than just to count up the numbers, and we intend to try to investigate that more difficult issue over the upcoming year.

Chairman **Sasser**. Well, are we seeing equal numbers of hospital closures in rural and urban areas, or are we seeing an undue concentration of closures in rural areas? I ask that question, because I think all four of the hospitals, if I am not mistaken, that closed in my State of Tennessee this past year were rural hospitals.

Mr. **Steinwald**. Our evidence would suggest that it is roughly equal numbers in urban and rural areas.

Chairman **Sasser**. Well, I know that Senator Simon was saying that hospitals were closing in the urban areas of Chicago that serve the poor.

Mr. **Steinwald**. Yes, sir.

Chairman **Sasser**. So, you are saying the closures are equally distributed between urban and rural?

Mr. **Steinwald**. That is correct. In fact——

Chairman **Sasser**. I have a hunch that if you get deeper into that, you are going to find that the hospitals that are closing are serving poor urban areas and also serving rural areas where there is a relatively low per-capita income. I am just guessing that is the case.

Mr. **Steinwald**. Senator, we will put it on our agenda to test your hypothesis. There are——

Chairman **Sasser**. If I am right, get back to me. If I am not, just forget about it. [Laughter.]

I would like to know the answer to that question. Now, how much of the problem in hospitals, the cost squeeze of hospitals, is being generated by medicare, or are there reasons other than medicare reimbursement or inadequate medicare reimbursement that are forcing hospitals to close?

Mr. **Steinwald**. Senator, I think that foremost on the list of reasons is under-used capacity. That is, we have an industry, a multiproduct industry, whose principal product had the demand fall through the basement early in this decade.

Chairman **Sasser**. This over-capacity and decline in demand, was that not a function of medicare tighten its system of payments and trying to get people out of the hospitals quicker?

Mr. **Steinwald**. No, sir, I do not believe so.

Chairman **Sasser**. All right, what was the cause of it?

Mr. **Steinwald**. I wish I had a clear answer. It began—now, we must make a distinction between rates of admission to hospitals and length of stay once the patient is admitted.

Chairman **Sasser**. In other words, rates of admission are probably up——

Mr. **Steinwald**. They are not, but——

Chairman **Sasser** [continuing]. But length of stay is down?

Mr. **Steinwald**. In the early years of the program, length of stay went down, as anticipated, but admissions also went down, and there is no incentive built into the payment system that would lead you to expect admissions to fall. Many of the critics of the prospective payment system, before it was enacted, expected it to cause admissions to rise, and yet they fell, and because they fell, hospitals were left, many of them, with under-utilized capacity, very low occupancy rates, and it is true that medicare is a volume-based payment system that pays on the basis not of the hospital's cost but on the volume of the medicare patients that it sees.

So, the combination, I believe, of the declining admission rates with the new payment system I think did in fact lead to the financial deterioration of many hospitals.

Chairman **Sasser**. Do you have a hypothesis as to why there would be declining admission rates in the hospitals? It appears to me that, with the population aging, the admission rates would be going up.

Mr. **Steinwald**. Once again, Mr. Chairman, I think part of the reason is imbedded in changes in practice patterns and in medical technology that permitted many more treatments to be safely performed outside of the hospital, rather than inside the hospital. And it was a combination of doctors and their patients taking advantage of that new technology that led much of patient care outside of the inpatient setting.

Chairman **Sasser**. Do you have additional questions, Senator Exon?

Senator **Exon**. I have no further questions of this panel, Mr. Chairman. Thank you.

Chairman **Sasser**. Let me direct one question to Dr. Ginsburg. With regard to the growth in part B outlays for physicians, Dr. Ginsburg, what is the best thinking about how these increases can be controlled, and can you tell us what you think of the proposals for regional expenditure caps similar to those that are used in Canada?

Dr. **Ginsburg**. The Commission has been calling them expenditure targets, rather than caps, but we have been looking at them for over a year now and in the process we have been developing in more and more detail a possible proposal to use in the medicare program. The Commission has not yet voted on whether to recommend it to Congress, but it is clear that there is a lot of enthusiasm on the part of some of the members of the Commission for the potential of this target.

There is a resemblance to what is being increasingly used in Canada, where some provinces under formal systems establish a target, and if the target is exceeded there is a direct, quickly applied mechanism to reduce fees in order to get back within the targets. Other provinces apply it in a more informal way, there is an assumption about a rate of increase of utilization built into the negotiation each year, and if actual utilization exceeds the assumption, that becomes a factor in next year's bargaining. So, there are examples throughout Canada and in West Germany for the use of this system.

Clearly, if it was developed for the United States we could not just transplant it without changing it. Our system is very different, particularly the fact that we have multiple payers for services, and the Federal Government at present would only focus on the medicare payment process.

Chairman **Sasser**. What is the best thinking on how these increases can be controlled? Is that the best thinking on it, the regional expenditure cap approach?

Dr. **Ginsburg**. Well, I would say where people agree today is that there are significant amounts of services that are provided to medicare beneficiaries that do not benefit them. Either they are services that are not contributing useful diagnostic information, say, diagnostic tests, or they harm more patients than they help. There has been growing literature that a certain proportion of procedures are inappropriate, and inappropriate is designed not to say that they are not worth the money, but just that the medical risks to the patients exceed the potential medical benefits to the patients.

Everyone agrees that the best way to reduce costs in the program is to have fewer of these inappropriate services done, and most people agree with the virtues of conducting additional effectiveness research and developing practice guidelines for physicians. There is probably disagreement, but I think increasing interest and support for the notion that we can get a much faster, stronger response from the medical profession to tackle this appropriateness issue through the use of some type of expenditure target system.

Chairman **Sasser**. One final question, Dr. Ginsburg. You have indicated that under part B, physicians payments are going up 13 percent a year; 2 percent of that is a result of patient growth. If you subtract, say, 5 percent of that as the rate of inflation—and that is about half a point above where the CPI has been I think for the last year or two—that is going to leave you with 6 percent. Now, where is that 6 percent going? Are the doctors just making 6 percent more above the rate of inflation, putting that in their pocket, or where is it going?

Dr. **Ginsburg**. If you look at the amount of payments in medicare per physician, those payments are increasing substantially. The physicians are providing more services and they are getting paid for the additional services. So I would expect that physicians' incomes from the medicare program are increasing much more rapidly than their fees are.

Chairman **Sasser**. Gentlemen, if there are no further questions, I thank you for appearing before us today.

Anything further, Jim?

Senator **Exon**. Nothing further, Mr. Chairman.

Chairman **Sasser**. Gentlemen, thank you very much for your attendance here today and your testimony has been very, very helpful.

Good luck to you, Mr. Steinwald, with your new addition.

Mr. **Steinwald**. Thank you.

Chairman **Sasser**. Our next panel of witnesses consists of Mr. John Casey, Dr. Raymond Scalettar, and Ms. Lovola Burgess, if you would be good enough to come forward.

I would like to welcome Mr. John Casey, the President of the Methodist Hospital System, in Memphis, TN, representing the American Hospital Association. I have known John Casey for some time and I want to say I am glad that the committee is going now to get the benefit of his wisdom.

We are also delighted to have with us today Dr. Raymond Scalettar, a practicing physician here in the District of Columbia, a member of the American Medical Association Board of Trustees; and last but certainly not least, Ms. Lovola Burgess, vice president of the American Association of Retired Persons, from Albuquerque, NM.

I would like to take each of your statements in turn and we will have some questions. I would like to ask you to summarize your written statements as much as possible. The closer you could keep your remarks to 5 minutes, the better we would like it, but if you must run over, why, we certainly understand. Dr. Scalettar and Ms. Burgess, if you would be good enough to introduce your associates here for the record. Dr. Scalettar, who is your associate?

Dr. **Scalettar**. This is Mr. Bruce Blehart, of the American Medical Association, Department of Federal Legislation.

Ms. **Burgess**. And this is Stephanie Kennan, who is from the Federal Affairs Staff of AARP here in Washington.

Chairman **Sasser**. Well, we welcome you both to the committee. Mr. Casey, we will start with you this afternoon and see what the American Hospital Association has to say about this whole subject.

STATEMENT OF JOHN CASEY, PRESIDENT, METHODIST HEALTH SYSTEMS, INC., MEMPHIS, TN, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. **Casey**. Thank you, Mr. Chairman.

I am pleased to have the opportunity to present testimony on fiscal year 1990 budget proposals affecting the medicare and medicaid programs on behalf of the American Hospital Association and its over 5,000 member hospitals.

You have been, as you noted, furnished in advance a document that was prepared by the AHA staff on our behalf, which both expresses our serious concern for the budget as proposed and offers some suggestion for certain changes that could begin to correct the current inadequacies in the system.

I personally would like to use this few minutes to simply emphasize a couple of the key points in that document and to offer some elaboration from the standpoint of one who works in a system that operates 13 hospitals in 3 States, those hospitals ranging from 50 beds in a rural facility in middle Mississippi, which by the way, I am told, the poorest county by per capita income in the United States——

Chairman SASSER. Which county is that, Mr. Casey?

Mr. CASEY. Holmes County.

Chairman SASSER. Holmes?

Mr. CASEY. Yes, sir—to a typical 200-bed suburban hospital, to an over 1,000-bed urban teaching hospital and referral center. The problems faced by these various institutions are somewhat different, but they are all very real.

First and most compelling is the fact that in the past 5 years under the prospective payment system, hospitals in this country have experienced substantial reductions in medicare funding relative to the cost of providing care to the beneficiaries.

Most thoughtful people in the hospital field welcomed in 1983 the challenges posed by the implementation of prospective payment and the incentives that it offered for the first time for trimming the fat out of the system and for rewarding effective management.

In the first 2 years of the system, we believe that we experienced the positive impact of these incentives, and it seemed for a time that everyone was pleased with the result, which we considered to be a more cost effective hospital system.

Unfortunately, in the past several years the rules have changed and the pendulum has now simply swung too far. Highly regarded and well-managed hospitals and systems across this country are suffering operating losses, both in medicare and medicaid and in their overall operations, as the private sector increasingly makes it clear that they are unwilling to continue to pay the hidden tax of cost-shifting.

It is estimated by the AHA that in 1989, this calendar year, over 60 percent of the hospitals in this country will lose money on medicare. Mr. Chairman, in our home State of Tennessee, over half of the approximately 150 hospitals experienced negative operating margins overall last year. In our own regional system, at least two of our rural facilities would have inevitably closed by now had it not been for our ability and willingness to carry them as part of our overall corporate mission.

If the proposed administration's budget is approved as it now stands, it is unclear how much longer many of these troubled facilities can continue providing services to their respective communities. The impact of closure of a hospital facility in a community often has far-reaching impact beyond simply affecting access to health care facilities.

Finally, let me summarize simply by saying that we are sympathetic to the dilemma that you and your colleagues face in prioritizing the economic requirements of our society through our government. However, we believe that the facts do show that hospitals have in recent years already contributed disproportionately to the solution to that problem.

Perhaps in the past we have been guilty of crying wolf too often, and I do not wish today to be overly dramatic and certainly not inaccurate in making this statement, but I can sincerely say to all of you today that at least I personally believe that unless corrective action is taken to insure a consistent and fair level of funding for the medicare and medicaid programs, that within the next several years our hospital system, or at least some significant component within it, will be in serious crisis, and we will increasingly be unable to deliver on the promise that you and we have made for access to a quality health care delivery system to the elderly, the poor, and to all of our citizens.

Thank you.

Chairman SASSER. Thank you very much, Mr. Casey.

[The prepared statement of Mr. Casey follows:]

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Statement of the American Hospital Association before the Budget Committee of the United States Senate on Medicare and Medicaid Budget Priorities for the 1990s

March 8, 1989

Summary

In recent years, hospitals have absorbed much of the burden of federal deficit reduction. Further cuts of this magnitude are a direct threat to hospitals' ability to maintain access to the high-quality care Medicare beneficiaries and others expect and deserve.

Of $21.9 billion in proposed overall budget cuts below current-law levels for FY 1990, hospital payment reductions would constitute over 15.5 percent, while Medicare hospital payments comprise just over 5.4 percent of federal outlays.

While the budget plan contains a welcome and long overdue expansion of Medicaid services for poor and near-poor women and infants, the Medicare proposals seem more driven by a desire to reduce federal outlays than a commitment to fulfill the promise of providing access to high-quality health care services for the nation's elderly.

The AHA believes there should be no further cuts in Medicare payments to hospitals. Furthermore, additional funds are needed to improve the adequacy and equity of Medicare prospective payments.

It is essential that Congress demonstrate its commitment to Medicare by rejecting the Administration's proposed cuts. Similarly, making good on the promise of expanded access to needed medical care for the nation's poor and uninsured requires a commitment to both expand Medicaid eligibility and to place the program on a sound fiscal footing.

Mr. Chairman, my name is John Casey, and I am the President of the Methodist Health Systems Inc. in Memphis, Tennessee. On behalf of American Hospital Association's (AHA) nearly 5,300 member hospitals, I am pleased to present testimony on issues related to Fiscal Year (FY) 1990 budget proposals affecting the Medicare and Medicaid programs.

Trends in Medicare

The past five years have seen substantial reductions in Medicare funding. Despite these reductions, hospitals have struggled to maintain their commitment to delivering high-quality care for the nation's elderly and disabled. Quality and access have been maintained, but both are threatened by further cuts.

While several studies document the magnitude of these reductions, we believe it is generally fair to conclude that hospitals have indeed contributed more than their fair share toward efforts to reduce the federal deficit. The most recent study on the matter, published in the New England Journal of Medicine last week, concluded that Medicare payments for inpatient hospital care in 1990 will be about $18 billion lower than they would have been had trends prior to implementation of the prospective payment system (PPS) continued.

Unfortunately, the Administration's proposed budget calls for further reductions in payments to hospitals as compared to current law. The combined impact of these proposals would be a more than 5 percent reduction in payments for inpatient care, as well as an equally large reduction in payments for outpatient care beginning in FY 1991.

This pattern continues under President Bush. Assuming the Bush budget conforms with the final Reagan budget, for FY 1990 it will recommend Medicare hospital payment policy changes that would result in reductions of $3.4 billion below current-law estimates. Of the Bush Administration's $21.9 billion in recommended total budget cuts, Medicare hospital payment reductions would constitute over 15.5 percent of the total, even though such payments comprise just 5.4 percent of total federal outlays. Moreover, the effects of the entire Medicare budget proposal would result in $42 billion in additional cuts below current-law from FY 1990 to FY 1994.

Since 1985, the annual increase in prices under the PPS has been held to a level less than inflation. Moreover, continued uncertainty over payments under PPS has already seriously reduced the ability of hospitals to manage their resources effectively and efficiently --the two primary goals of PPS.

Since we still do not know the details of the new Administration's budget, we can only assume they mirror those proposed in the last Administration's FY 1990 budget. If so, they would include:

-- a 1.5 percentage point reduction in the annual update to the standardized rate for inpatient hospital services--that is, market basket minus 1.5 percent;

-- a 25 percent reduction in capital payments;

-- a reduction in indirect medical education payments of 47 percent; and

-- a 5 percent across-the-board reduction in outpatient payments beginning in FY 1991, growing to a 12 percent reduction in FY 1994.

Medicare Hospital Payment Outlays

Exclusive of benefit expansions in Medicare catastrophic coverage law, Medicare spending for inpatient hospital care under current law is projected to increase about 11 percent in FY 1990. But that 11 percent growth is the result of the following four factors: inflation in prices of goods and services used by hospitals; increases in the size and average age of the Medicare beneficiary population; a more seriously ill patient population; and expiration of certain payment reductions in effect during FY 1989.

Specifically, the Administration's budget assumes a hospital market basket increase of 4.7 percent; population growth and aging account for a 3.2 percent growth in outlays; the Medicare case-mix index (a measure of the complexity of Medicare hospital cases) is projected to rise about 1 percent; and the expiration of the current 15 percent reduction in capital payments will increase per-case payments 1.9 percent.

All the factors cited above are beyond the control of hospitals; nevertheless, the Administration's budget essentially requires hospitals to absorb the bulk of their impact. Despite an aging and growing beneficiary population that is more seriously ill, and more difficult to treat, hospitals would be expected to provide care next year at an aggregate expenditure level just about equal to this year's after controlling for inflation.

Unfortunately, the nation's hospitals simply do not have the reserves to do this. Such reductions would threaten directly both access to and quality of hospital care. Some hospitals would be forced to close their doors entirely, others to shift the burden to other payers, and still others to eliminate certain specialized but very costly services, reduce the hours of operation for some departments, lengthen the time patients must wait for nurses, or take other actions that compromise the availability and quality of care that we, as Americans, have come to expect of our health care system.

To illustrate the point better, I would quote from a recent interview conducted by AHA researchers with a Tennessee colleague of mine about cost pressures on his hospital:

> "The patients in our community are aging, and the number of people who are in the Medicare ages has increased. Patients have multiple conditions complicating admission, diagnosis, and treatment, which causes them sometimes to stay longer and require more intense services than other patients. This has also helped to increase the cost of care for this group of patients. Also, in this age group the family support and involvement has not been as good as it perhaps should have been. This again takes more resources for the hospital, either by having them stay longer than they should or by having to make arrangements for them to be transferred to an appropriate facility for sub-acute care. We've found that facilities are not available when some of our cases require facilities outside the hospital."

Mr. Chairman, I would suggest to you that the situation being described by this administrator is occurring routinely throughout the nation.

Impact of Cuts

Our current projection is that in FY 1990, payments by Medicare to the average hospital will fall short of costs by between 8 and 9 percent. Nearly two-thirds of all hospitals will lose money caring for Medicare patients, nearly half will incur deficits of 10 percent or more, and nearly 30 percent will incur losses of 20 percent or more. These projections are practically the same for urban hospitals, rural hospitals, teaching hospitals, and non-teaching hospitals. It is against this background that the Administration's proposals to reduce hospital payments $3.4 billion must be weighed.

There are two primary reasons for declining hospital margins: payment reductions in every budget reconciliation bill enacted by Congress since PPS' inception, and rising costs. The "bottom line" is that the combination of less-than-inflation updates in prices and higher-than-market-basket increases in costs has caused payments by Medicare to fall far short of the cost of caring for Medicare patients.

In addition, indirect medical education (IME) payments have been curtailed sharply. Since 1984, changes in the indirect medical education payment formula have cut these payments between 30 and 40 percent, depending on the level of involvement of the hospitals in graduate medical education. These reductions translate into reductions in aggregate PPS-related payments to teaching hospitals of between 2 and 12 percent. Although teaching hospitals were singled out by the Inspector General of the Department of Health and Human Services in the first year of PPS as having Medicare operating margins substantially above the average, that situation no longer prevails. Teaching hospitals are, on average, no better off than hospitals generally, and some are even experiencing larger deficits than non-teaching hospitals.

Any further reduction in the indirect adjustment would jeopardize the financial status of many teaching hospitals whose IME payments comprise an average 20 percent of their total Medicare payments. Moreover, while margins have declined for all hospitals in FY 1988, teaching hospital margins have declined an average 67 percent from FY 1987 to FY 1988. Reductions in the adjustment for teaching hospitals would force them to make substantive changes in the services they offer and the resources they use.

Further exacerbating the economic pressures on hospitals are a variety of other deficit reduction measures enacted over the years, measures that have affected everything from capital to outpatient payments.

Causes of Rising Hospital Costs

Many have argued that hospital margins would not have plummeted if hospitals had kept their costs under control. But there are legitimate reasons for hospital cost increases, which are directly associated with the very real demand for patient care and services and are beyond the control of hospital managers. Perhaps a New Mexico hospital administrator said it best in his interview with AHA researchers:

> "It's kind of a hard thing to pick out one specific area and identify that as the reason for cost inflation because most of these things have an impact on us. We see more comorbid conditions. We've seen longer inpatient stays because of lack of subacute facilities. The

> cost to maintain the equipment, recruitment costs, benefit costs, contract labor costs, education costs, the costs of materials, all of these have affected us. Utility costs have risen. Data processing costs are higher. The cost of compliance with regulations has gone up. Malpractice premiums have gone up. To say that one factor is the cause would be a misnomer because so many things are a part of the problem."

Health care is a unique product, and neither the provider nor the recipient is prepared to compromise on quality. Simply put, we all want and believe we deserve the best care possible. More specifically, there are several reasons for hospital costs rising above the Medicare market basket:

-- First, hospital costs are rising more rapidly than the Medicare market basket because the market basket fails to reflect accurately the increase in costs of the most important resource used to care for patients--the hospital's staff. Many types of hospital personnel are in short supply--particularly nurses, who typically comprise about one-half of total staff. As a result, hospitals must provide more rapidly increasing wages and benefits than offered to employees in other sectors of the economy. Nevertheless, Medicare bases its measure of "inflation" on changes in wages in other parts of the "private sector." The use of price proxies instead of an actual assessment of labor costs may understate the rate of hospital input price inflation by 2 to 4 percentage points.

-- Second, patients admitted to hospitals today are more seriously ill and require more complex treatment than patients admitted in 1984. Many "short stay" procedures have been moved outside the hospital. Treating more severely ill patients in the hospital requires a higher skill mix of employees. It is reasonable to project that this phenomenon accounts for an additional 2 to 4 percentage point increase in costs beyond inflation.

-- Last, advances in medical technology, which offer patients the hope of receiving less-invasive treatment and thus reduce pain and risk, significantly add to the per-case cost of treating hospital patients. The demand for more sophisticated tests and procedures has increased dramatically as consumers become aware of scientific advances. These costs are not always reflected in the measure of inflation used by Medicare.

Despite these pressures, hospitals have made efforts to increase productivity and contain costs. In fact, hospital productivity has increased significantly since the inception of PPS. Specifically, the number of full-time equivalent staff per adjusted admission has remained constant since 1984, despite increases in the acuity level of cases in both inpatient and outpatient settings. And hospitals continue to make every effort to improve efficiency in both the use of services and delivery of care. The evidence for these efforts is found in shorter lengths of stay and successful efforts to hold the line on increased staffing despite the admission of more patients needing more intensive care.

RECOMMENDATIONS

General Comments

Many individuals and entities involved in health care policy continue to debate the future direction of the health care system.

The AHA hopes that in addressing the nation's immediate concerns about the deficit, the new Administration and Congress will give more careful consideration to the long-term consequences that yearly budgetary decisions are beginning to have on the delivery of health care services.

In light of the fact that the Medicare hospital insurance program is financed by a dedicated payroll tax, we seriously question the advisability of using outlay reductions in this program as a tool for temporarily increasing Hospital Insurance Trust Fund surpluses, so that they may be used to mask the deficit being run in the unified budget.

Changes in both the Social Security and Medicare programs should be based on sound policy considerations rather than on short-term budgetary strategies. To ensure that Medicare payment policy issues are decided on their merits, the AHA believes that the hospital insurance program should be immediately removed from the unified budget and exempted from sequestration under the Gramm-Rudman-Hollings deficit reduction law.

As you know, development of PPS was a major policy reform enacted in the early 1980s with the support of the hospital field. However, since then, hospital payments have been significantly reduced, largely because of the deficit reduction imperative. It is clear that decisions are no longer being made in accord with the original goals of the program.

Implementation of PPS and its transition to national payment rates have resulted in a redistribution of Medicare hospital payments. When this system was created, it was widely acknowledged that there would be problems down the road, problems inherent in the reshuffling of any payment system involving the distribution of tens of billions of dollars.

Unfortunately, as a result of the deficit dilemma, efforts to address these problems have been implemented in a budget-neutral manner, which often means robbing Peter to pay Paul. For example, urban hospital payments have been reduced to increase rural hospital rates, and teaching hospital payments have been reduced to increase rates paid to hospitals serving large numbers of low-income patients. These changes were effected more easily in a budget-neutral manner in the early years of PPS when most hospitals experienced positive operating margins, but we simply cannot continue to operate under these circumstances when nearly two-thirds of the hospitals in the nation are losing money every time a Medicare beneficiary walks through their doors.

In short, we believe that there should be no further cuts in Medicare payments to hospitals. Moreover, it is our view that additional funds need to be provided to improve the adequacy and equity of payments under PPS.

Therefore, for FY 1990 we urge that proposed reductions in both capital payments and the indirect medical education adjustment be rejected. Moreover, we believe that all hospitals should receive, at a minimum, a full market basket update to their PPS rates.

Specific Proposals

Adequacy of Payment

Over time, Medicare payments to hospitals must bear a reasonable relationship to costs incurred in providing needed medical care to patients. To achieve this goal, the AHA recommends that payments be recalculated periodically based on current cost data. The Association believes that such a recalculation should include a recognition of costs associated with providing care to the medically indigent, as well as an appropriate level of funding to underwrite the risk experienced by hospitals under a fixed per-case payment system.

Rates should be recalculated every four years using an expanded definition of the cost of caring for Medicare patients. Between these quadrennial recalculations, prices should be updated by the percentage increase in the price of goods and services that hospitals must purchase to provide care. For providers exempt from PPS, a more timely means of adjusting payment limits of individual providers for change in case mix and treatment is needed.

This recommendation is a significant change in the Association's position. While we have categorically rejected previous attempts to "rebase" the system that were driven solely by deficit reduction demands, our current position is based on a recognition that an objective standard is needed for judging whether PPS rates are adequate. Since the Prospective Payment Assessment Commission (ProPAC) and Congress have implicitly relied on hospital operating margins as the standard for judging adequacy, adopting this position would simply make that standard explicit.

Such an approach would provide hospitals with payment predictability--a fundamental principle that was promised when PPS was instituted--to allow hospital managers to undertake financial planning necessary to operate their institutions efficiently.

Because payments to individual hospitals would not be linked to their own costs but to changes in aggregate or system-wide costs, incentives for individual hospitals to improve efficiency would be preserved.

Equity Improvements

Nearly every reconciliation bill includes provisions that attempt to improve equity. These have ranged from addressing the problems experienced by hospitals that serve high volumes of low-income individuals to the special problems faced by rural hospitals. We view our recommendations as a systematic approach to build on the efforts undertaken by Congress and the Administration.

Our equity proposal includes four basic elements:

First, we recommend establishment of a single base rate, adjusted for differences in the kinds of patients admitted to hospitals and for differences in the prices hospitals must pay for resources.

However, our support for this approach is contingent upon two factors:

- the single base rate should not be implemented without refined adjustments for patient mix and resource prices that are described below; and

- movement to a single-rate system must be accompanied by a "hold-harmless" provision that protects hospitals from a reduction in payment resulting from movement to the single rate. In other words, we cannot support efforts to achieve a base rate simply by cutting urban hospital payments to increase rural hospital payments.

Second, the diagnosis-related group (DRG) system has been widely criticized for its failure to capture the "severity" of a patient's condition, and while we believe that a comprehensive severity adjustment should eventually be implemented, none of the current systems has reached a state of development and validation that would warrant its adoption. Until such a system can be embraced, a program of DRG refinement should be adopted. Efforts should focus on refinement of "problem" DRGs, which account for more than 1 percent of Medicare admissions and which show substantial variation in costs.

Third, PPS rates are currently adjusted only for differences in prevailing wage levels. In the long term, we believe that a comprehensive adjustment should be developed that accurately reflects prices paid by hospitals in local markets for all types of resources. In the interim we propose:

- that the existing wage index should be updated to reflect current wage levels;

- regional differences in liability insurance and energy costs should be adjusted for; and

- an exceptions and appeals process should be created to correct payment problems that are clearly beyond the control of hospital management and medical staff.

In fact, in both the long and short term an exceptions or appeals process will always be needed to take into consideration unique circumstances of individual hospitals that cause them not to fit a general rule. All routine adjustments assume that hospitals are "average" and will continue to work well for a majority of hospitals. But some hospitals will simply not fit into such a system of averages.

Fourth, given that small rural hospitals may lack the volume that is essential to a payment system based on averages, rural hospitals that operate fewer than 50 beds should be given the option to receive cost-based payments. In addition, criteria should be developed that would permit larger hospitals, including selected urban hospitals that are the sole source of care for their communities, to seek and receive an exemption from PPS.

Finally, we recommend other changes related to PPS that include refinements in payments for sole community providers and an extension of current payment policies for rural referral centers.

The Medicaid budget

The last Administration proposed a $1.7 billion reduction in Medicaid expenditures to be achieved through reductions to states in federal matching funds, the application of more restrictive eligibility criteria, and other miscellaneous measures. The Bush Administration now proposes merely to continue Medicaid expenditures in FY 1990 and beyond at the "current services" level.

Although some of the provisions of the Reagan Medicaid proposals have been carried over, including cuts in special administrative matching funds to the states, the Bush Administration proposes a substantial increase in eligibility. Specifically, mandatory eligibility would be added for pregnant women and infants who have family incomes up to 130 percent of the federal poverty level. This expansion in eligibility is long overdue and will address the needs of possibly 150,000 uninsured Americans.

The change in philosophy between the Reagan proposals and the proposals of President Bush is welcome. By the early 1980s Medicaid covered less then half the population living below the federal poverty level. Hospitals, through the privately insured patients they cared for, financed the social safety net that made needed medical care available to the nearly 37 million uninsured Americans. The Administration's proposal builds on Congress' mandate to improve Medicaid coverage for pregnant women and infants. Members of Congress have already responded to President Bush's interest in this area and proposed legislation to phase-in expanded eligibility for pregnant women and infants (S.339, H.R.833) and to require coverage for technology dependent children

(H.R.832). The AHA strongly supports these legislative initiatives as important measures to assure access.

The silence of the Bush Administration on the question of how expanded eligibility will be funded is troubling, however. Reductions in federal administrative matching funds to states at the same time they are being asked to enroll a larger number of people may lead to further reductions in provider payments. Providing an entitlement to services without making sure that those providing the care are able to deliver it is an empty promise. It is essential that Congress ensure adequate funding is provided to fund high-quality health services for Medicaid populations. The AHA has joined a broad-based coalition, including providers, labor, and social service groups, calling on Congress to increase Medicaid funding to support needed programmatic reforms.

Conclusion

The priority health policy issue facing the nation is how to reconcile the need and demand for access to the highest quality medical care with the nation's limited resources. For Medicare, this means putting the program on a financially sound footing and ensuring the effective and efficient use of the program's resources without compromising quality. For Medicaid, this means finding a way of adequately funding access to services for the nation's poor and uninsured who are unable to purchase private health insurance coverage.

Reductions in payment that have been proposed by the Bush Administration would seriously compromise the ability of hospitals to maintain access to essential, high-quality medical care for Medicare beneficiaries.

Making sure that all Americans have access to care should be the fundamental goal of Medicaid. A minimum national eligibility floor for Medicaid would assure such access for the nation's neediest individuals. The President's interest and Congress' initiatives in eligibility expansion are important steps toward this goal. Other reforms are needed in the areas of enrollment incentives, financing, reimbursement, and coverage policies. The AHA will continue to work with Congress to address these much-needed reforms.

For both programs, a stable and reliable funding mechanism must be in place to fulfill the promise of health care services to the poor, disabled and elderly.

As the New Mexico Hospital Administrator told AHA:

> "The most valuable contribution we make is we provide needed medical services. We're the only hospital in the area, the only game in town. The next one is 90 miles away.
>
> To the community itself, I would say that in any community--not just this one--you have to have a viable hospital if you expect to grow economically. So I would say that a good hospital is essential to the economic well-being of the community. Your businesses won't come if you don't have a hospital, and they'll leave if you don't."

Although AHA recognizes the importance of reducing the federal deficit, we believe hospitals have already contributed disproportionately to the effort. A significant effort is needed to make Medicare and Medicaid more fiscally reliable and to make the reforms that will ensure adequate payment and equitable treatment both for hospitals and program beneficiaries. The AHA has recommended several actions that can be taken to achieve those goals and looks forward to working with the Congress in an effort to assure access to high-quality, cost-effective medical care for all Americans.

Chairman SASSER. Dr. Scalettar, we are going to give you now equal time to refute the statements that came before you here, not from Mr. Casey but from the previous panels. Please go ahead.

STATEMENT OF DR. RAYMOND SCALETTAR, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY BRUCE BLEHART, DIRECTOR OF THE AMA'S DEPARTMENT OF FEDERAL LEGISLATION

Dr. SCALETTAR. Thank you very much, Mr. Chairman. I will present a summary statement. You have already introduced Mr. Blehart.

At the outset, let me state as clearly as possible that the medicare program has already been subjected to over a decade of major cuts. Further cuts will jeopardize our ability to provide necessary services to our elderly and disabled patients. It is time to stop trying to balance the budget on the back of the medicare program.

In making this statement, we also acknowledge the dilemma you are facing. We understand that there is a compelling need to reduce the deficit and that the medicare program represents a substantial component of the budget and must be subject to scrutiny.

Absent a determination to apply an across-the-board approach to freeze all Federal spending, however, the American Medical Association cannot endorse further cuts being made in the medicare program. If there is no across-the-board measure and if you decide that further cuts in medicare are unavoidable, the AMA believes that any reductions should be done in proportion to the actual outlays between Medicare's components.

At this point, we challenge and want to dispose of the mistaken impression that physicians have been relatively untouched by past budget-cutting actions. Recent statements in the press have pointed to the part B side of medicare as "the only place that hasn't experienced the crunch." Our experience is contrary and the facts are incontrovertible. Our experience says that medicare reimbursement and fees were frozen for most physicians for 40 months, from July 1983 to 1987. The medicare allowed amount for an office visit is only 73 percent of the amount actually billed by physicians to other patients, and physicians presently are the only profession subject to Federal price controls.

The facts on past medicare cuts clearly indicate that physicians have taken more than our fair share. According to a recent GAO report, the sum of budget savings through 1986 shows cuts of approximately $18 billion for part A and $13 billion for part B. This represents an almost 7 percent reduction in cumulative part A outlays and 11 percent reduction in cumulative part B outlays. The bottom line is that relative to respective program sizes, part B was cut about one and a half times more than part A.

The AMA recognizes that reasonable discussions on medicare spending also must address the twin issues of volume and appropriateness of care. We are very concerned that there has been an increasingly reflective perception that there is a broad "volume problem," and suspect physician behavior often is alluded to as a primary cause of this problem. As a result of this perception, there has been growing interest in complex regulatory policies to achieve budget savings through controlling volume growth and reducing levels of alleged unnecessary care.

The AMA is against any unnecessary care, and we only wish that all of the needed savings could be generated by such a simple solution. The truth of the matter is that physicians are not causing vast unnecessary program expenditures. The facts are that people are living longer, our ability to provide care has eclipsed projections, and the care that we can provide is substantially different and better from what was available only a few short years ago.

A further factor which has led to the increased demand for care is that the cost-sharing provisions of part B have eroded. We believe that a review of care, to be successful, must be based on physician developed appropriateness criteria and on coverage decisions that preserve patient access to quality medical care.

With this in mind, we have taken a lead role in the development of practice parameters which we view as a workable solution to help assure the provision of high-quality care, to which you have heard Dr. Ginsburg allude to before. Through the American Medical Association's Office of Quality Assurance and Assessment, we are pursuing the development of practice parameters with the Rand Corp.

Mr. Chairman, it is impossible to discuss medicare part B savings without also discussing mandatory assignment and future directions for physician reimbursement policy. There is little dispute that the medicare methodology for setting physician payment and reimbursement levels is overly complex and often creates inequitable results.

The fact that currently recognized physician reimbursement and payment levels use 1971 actual charges as their starting point and have been subjected over the years to a myriad of controls illustrates why the system is fraught with inequities.

The AMA strongly supports a rational review of physician reimbursement, as has been conducted recently through the Harvard University School of Public Health, which published its resource-based relative value scale, RBRVS, and to which Dr. Ginsburg referred to before.

In our review, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions. The AMA believes that such a payment system could ameliorate many of the uncertainties inherent in current medicare payments and ameliorate inequities, and it would not be as inflationary as the current payment system.

On the issue of medicare assignment, we believe the current high rate of assignment, with close to 80 percent of charges being assigned, demonstrates that physicians are re-sponsive to their patients' needs. It is also important to note that physician balance billing does not represent a financial barrier to needed care. The data from PPRC's beneficiary survey report that only 6.4 percent of respondents did not seek care during the previous year because of the cost, with only 3.1 percent putting off treatment for a serious condition. Only 0.2 percent reported being actually denied care for financial reasons.

Although any delay in seeking treatment due to financial consideration is worrisome, these numbers do not suggest that balance bills or coinsurance exert a widespread negative impact to access.

Finally, limits on balance bills will pose a financial risk to the medicare program. Studies on the effects of cost-sharing by the Rand Corp. and the Congressional Budget Office indicate that elimination of balance billing could greatly increase medicare expenditures.

In conclusion, the American Medical Association urges you to reject the high-level of medicare cuts called for in the President's budget proposal. It is essential for you to remember that dollars cut from this program are felt in human terms. If our society is truly to move into an era where government is operating on a philosophy of being kinder and gentler, what better place to start than with a program designed to assure access to essential health care for our Nation's elderly and disabled.

Thank you. I will be happy to answer any questions.

Chairman SASSER. Thank you, Dr. Scalettar.

[The prepared statement of Dr. Scalettar follows:]

Statement of the American Medical Association

to the

Budget Committee
United States Senate

Presented by
Raymond Scalettar, MD

RE: Medicare and the Fiscal Year 1990 Federal Budget

March 8, 1989

American Medical Association
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Division of Legislative Activities
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PRINCIPAL POINTS

Statement of the
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RE: Medicare and the Fiscal Year 1990 Federal Budget

March 8, 1989

Absent a determination to apply an across the board approach to freeze all federal spending, the AMA cannot endorse further cuts being made in the Medicare program. Additional cuts in Medicare will only exacerbate the problem of Medicare bearing a disproportionate share of federal budget cuts.

With the impact of massive legislative changes from past budget directed actions not even fully known, we strongly caution against further program changes that are aimed at achieving dollar savings as opposed to rational program improvement. Program changes imposed in the name of dollar savings also carry a real impact on our patients.

Recent statements in the press have pointed to the Part B side of Medicare as "the only place that hasn't experienced the crunch." Our experience is contrary and the facts are incontrovertible:

- Both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. Relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.

There is little dispute that the Medicare methodology for setting physician payment and reimbursement levels is overly complex and often creates inequitable results. The AMA strongly supports a rational review of physician reimbursement, as has been conducted recently through the Harvard University School of Public Health which published its resource-based relative value scale (RBRVS). In our view, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions.

At this point, we believe that the current Harvard study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system.

Recent policy debates regarding the volume and appropriateness of care provided to Medicare beneficiaries have increasingly reflected a view that there is a broad "volume problem," and suspect physician behavior often is alluded to as a primary cause of this problem. The truth of the matter is that physicians are not causing vast unnecessary program expenditures. Major factors leading to program growth include:

- Improved techniques and technology that make consumption of medical care easier, safer, and more accessible;
- Patients being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- the cost-sharing provisions of Part B have eroded, resulting in increased demand for medical care.

The American Medical Association acknowledges that appropriateness of care and volume of services are related. We believe that review of care, to be successful, must be based on physician-developed appropriateness criteria and on coverage decisions that preserve patient access to quality medical care. One potential and we think workable solution to help assure the provision of high quality care is the development of practice parameters. The AMA is also working with the national medical specialty societies to refine research methodologies and develop dissemination techniques to provide useful and educational information to practicing physicians.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

BUDGET COMMITTEE
UNITED STATES SENATE

Presented by
Raymond Scalettar, MD

RE: Medicare and the Fiscal Year 1990 Federal Budget

March 8, 1989

Mr. Chairman and members of the committee:

My name is Raymond Scalettar, MD. I am a physician in the practice of internal medicine in Washington, DC, and I am also a member of the Board of Trustees of the American Medical Association. With me today is Bruce Blehart of the AMA's Department of Federal Legislation. The AMA is pleased to have this opportunity to testify before you today concerning proposals to cut up to $5.5 billion from the projected Medicare budget for fiscal year 1990.

Let me state as clearly as possible that the Medicare program has already been subjected to over a decade of major cuts. Further cuts will jeopardize our ability to provide necessary services to our elderly and disabled patients. It is time to stop trying to balance the budget on the back of the Medicare program.

The AMA appreciates the dilemma you are facing. We understand that there is the compelling need to find substantial savings in a federal budget when the deficit is so immense that interest on the national debt is the third largest component of the overall federal budget. On the other hand, further cuts in the Medicare program -- the guarantor of health care coverage for over 33 million Americans -- will impair our ability as physicians and as a society to continue the promises of this program. In your deliberations, we urge you to apply an evenhanded approach. Absent a determination to apply an across the board approach to freeze all federal spending, the AMA cannot endorse further cuts being made in the Medicare program.

Additional cuts in Medicare will only exacerbate the situation of having Medicare bear a disproportionate share of federal budget cuts. To update a point we presented to you one year ago:

> From 1980 to 1988, actual Medicare spending compared with Office of Management and Budget (OMB) projected current services spending shows that $7.9 billion was cut during this same period, and notwithstanding this sharp reduction in Medicare expenditures, total federal spending actually increased by $120.3 billion over OMB projected current services spending.

With the impact of massive legislative changes from past budget directed actions not even fully known, we strongly caution against further program changes that are aimed at achieving dollar savings as opposed to rational program improvement. Program changes, especially those imposed in the name of dollar savings, also carry a real impact on our patients.

At the outset, we challenge and want to dispense with the mistaken impression that physicians have been relatively untouched by past budget cutting actions. Recent statements in the press have pointed to the Part B side of Medicare as "the only place that hasn't experienced the crunch." Our experience is contrary and the facts are incontrovertible:

- Medicare reimbursement and fees were frozen for most physicians for 40 months from July 1983 to 1987;

- Medicare reimbursements for selected procedures were cut across-the-board by a total of 12% in 1987 and 1988, and special limits were imposed on physician fees for these procedures;
- The Medicare allowed amount for an office visit is only 73% of the amount actually billed by physicians to other patients (according to our 1986 survey); and
- Physicians presently are the only profession subject to federal price controls, the maximum allowable actual charge program.

Both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. The sum of the budget savings estimated by HCFA for ORA, OBRA-81, TEFRA, DEFRA, COBRA, and OBRA-86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988). This represents a 6.9 percent reduction in cumulative Part A outlays and a 10.9 percent reduction in cumulative Part B outlays. Thus, relative to the respective program sizes, Part B was cut about one and one-half times more than Part A. (A summary of recent actions limiting physician reimburcement and charges is attached as Appendix I.)

Nevertheless, in a $90 billion program where approximately $25 billion was spent for physician services in 1988 (compared with $48 billion for hospital care in the same year), some savings can be found. If there is to be no across the board measure, and if you decide that Medicare spending cuts are unavoidable, we believe that any reductions made in Medicare should be done in proportion to actual outlays.

Two weeks ago, the AMA's Board of Trustees considered the Medicare budget proposals set forth by President Reagan in his final budget submission. Our views on these issues are set out in the attached appendix (Appendix II). The issues which we feel essential to discuss in detail here are the overall issue of physician payment reform and the growing volume of Medicare services and expenditures.

Physician Payment Reform under Medicare

Mr. Chairman, it is impossible to discuss Medicare Part B savings without also discussing future directions for physician reimbursement policy under this program. There is little dispute that the Medicare methodology for setting physician payment and reimbursement levels is overly complex and often creates inequitable results. The fact that current physician reimbursement and payment levels are based on 1971 actual charges as their starting point and have been subjected over the years to a myriad of payment and fee controls illustrates why the system is fraught with inequities.

The AMA strongly supports a rational review of physician reimbursement, as has been conducted recently through the Harvard University School of Public Health which published its resource-based relative value scale (RBRVS). In our view, an indemnity payment system utilizing an RBRVS has the best potential for setting future physician reimbursement directions. The AMA believes that such a payment system could ameliorate many of the uncertainties inherent in current Medicare payments and ameliorate inequities. It also would provide patients with a greater understanding of the financial obligations for each service. The RBRVS study now is being analyzed by the Health Care Financing Administration, the Physician Payment Review Commission, the AMA and others. (Our analysis of this activity, unanimously adopted by our House of Delegates in December, 1988, is attached.)

At this point, we believe that the current Harvard study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system. The AMA has identified seven specific areas of the Harvard study that need additional work prior to its use in Medicare payment determinations:

- restudy of specialties whose RBRVS data have significant, documented technical deficiencies;
- fundamental improvement of the measurement of relative practice costs and specialty training costs;
- expansion of the RBRVS to more specialties and services;
- development of an extrapolation method for visits;
- revision, refinement, and expansion of pre- and post-service work measurement;
- expansion and validation of the current extrapolation method; and
- development of relative value estimates for global surgical services as standard definitions are developed and accepted.

Much of the work necessary to complete and improve the RBRVS is underway in the study's second phase. As a study subcontractor, the AMA is participating actively with Harvard and a number of specialty societies in the process of expansion and refinement needed to produce a technically adequate RBRVS.

Volume and Appropriateness of Care

Recent policy debates regarding the volume and appropriateness of care provided to Medicare beneficiaries have increasingly reflected a perception that there is a broad "volume problem," and suspect physician behavior often is alluded to as a primary cause of this problem. As a result of this perception, there has been growing interest in complex regulatory policies to achieve budget savings through controlling volume growth and reducing levels of unnecessary care. Although the AMA fully supports the elimination of unnecessary care --and we only wish that all of the needed savings could be generated by such a simple solution-- the truth of the matter is that physicians are not causing vast unnecessary program expenditures. Major factors leading to program growth include:

- Improved techniques and technology that make consumption of medical care easier, safer, and more accessible;
- Patients being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- the cost-sharing provisions of Part B have eroded, resulting in increased demand for medical care.

(A detailed analysis on this issue is attached to this statement as Appendix III.)

The American Medical Association acknowledges that appropriateness of care is directly related to the issue of volume. We believe that review of care, to be successful, must be based on physician-developed appropriateness criteria and on coverage decisions that preserve patient access to quality medical care. When utilization management programs are _not_ run properly, the provision of _quality_ health care to program beneficiaries is compromised. Too often, reviewers with little or no clinical training are given authority to deny claims as "not medically necessary." As we have seen, some carriers actually deny claims on the basis of "screen failure" alone without necessary claims development.

One potential and we think workable solution to help assure the provision of high quality care is the development of practice parameters. The AMA strongly supports the development of clinically relevant parameters that are designed to assure that patients receive appropriate medical care. Through our Office of Quality Assurance and Assessment, the AMA is pursuing its clinical appropriateness initiative with the RAND Corporation to develop practice parameters. The AMA is also working with the national medical specialty societies to refine research methodologies and develop dissemination techniques to provide useful and educational information to practicing physicians.

CONCLUSION

In conclusion, the AMA is eager to continue our work to develop a workable payment methodology for physician services and to help assure that the care provided is of the highest quality. As you continue your deliberations, we will make our expertise and our resources available for your assistance.

At this time we will be pleased to respond to your questions.

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APPENDIX I

Physician Reimbursement Restraints Under Medicare

Since the inception of Medicare, Congress and the Department of Health and Human Services have taken actions that have resulted in reductions in Medicare reimbursement for services provided by physicians for Medicare beneficiaries. The result of these actions has been that physician reimbursement under Medicare consistently has been compressed to a point where the maximum Medicare reimbursement rate, the "prevailing charge," usually does not reflect the actual prevailing charge for these services.

In 1969, prevailing charge levels were lowered from the 90th percentile to the 83rd percentile of customary charges. In 1970, prevailing charge levels were lowered to the 75th percentile of customary charges. For the second half of the 1971 fiscal year, physician's customary charges were based on the physician's median charge during the 1969 calendar year.

In August 1971, nationwide wage and price controls were imposed. While these controls were lifted seventeen months later for most of the economy, they still were retained for physicians for an additional fifteen months -- until May 1974.

In 1972, Congress established further restraints through use of an economic index as a means to limit the rate of annual increase in prevailing charge levels. In 1976, the Medicare Economic Index (MEI) as used to set the prevailing charge limits using fiscal year 1973 charge screens that were based on physicians' charges during calendar year 1971.

Starting with the Deficit Reduction Act of 1984 (DRA) further and substantial limits were imposed on physician reimbursement and charges for services provided Medicare beneficiaries. The DRA modified physician reimbursement in the following ways:

> Two classes of physicians were created: "participating" physicians who agreed to accept all Medicare claims on an assigned basis and "non-participating" physicians who may continue to accept assignment on a claim-by-claim basis;
>
> Medicare maximum reimbursement levels for physician services, customary and prevailing charge levels, were frozen for the period of June 30, 1984 to September 30, 1985 (if no freeze had been imposed by the DRA, the economic index would have allowed a 3.34% increase of prevailing charge levels on July 1, 1984);
>
> The scheduled July 1, 1984 increase in fee profiles was eliminated, and the future annual update in fee profiles was delayed from July 1 to October 1, with the next increase set for October 1, 1985; and
>
> Fees for services provided Medicare beneficiaries by "non-participating physicians" were frozen during this 15-month period. (Participating physicians were allowed to increase their fees for Medicare beneficiaries, but they are not allowed to collect this increased fee because of the agreement to accept assignment on all Medicare claims.)

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The Emergency Extension Act again froze physician payment levels at the rates in effect on September 30, 1985 for 45-days. (This Act prevented a 3.15% increase from being applied to Medicare prevailing charge levels on October 1, 1985.) This Act also rolled back the actual charge levels allowed physicians who "participated" in FY85 but who had not agreed to "participate" in FY86. Further legislation extended the Extension Act, with fee and reimbursement levels again frozen through March 15, 1986.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) yet again extended the Medicare reimbursement freeze: i) the freeze on Medicare reimbursement and charges for non-participating physicians was continued through December 31, 1986; and ii) the freeze in the customary and prevailing charge levels for participating physicians was allowed to end May 1, 1986, with the prevailing charge increase for participating physicians set at only 4.15%.

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) made substantial modifications in physician reimbursement and fee limits.

> Reimbursement - Both participating and non-participating physicians were allowed an equal 3.2% update in Medicare prevailing charge levels beginning January 1, 1987. Beginning on January 1, 1987, prevailing charges for non-participating physicians were set at 96% of the prevailing charge levels allowed participating physicians.
>
> Fees - The freeze on actual charges of non-participating physicians expired on December 31, 1986 and was replaced by Maximum Allowable Actual Charge (MAAC) limits. Each MAAC is determined by a complicated formula applicable to every charge of every individual physician. Physicians are subject to substantial penalties for violation of MAAC limits. MAAC limits are determined as follows:
>
>> If the physician's actual charge for any given service is at or above 115% of the prevailing charge (as determined from year to year), the actual charge for that service may be increased by no more than 1%. If the actual charge is less than 115% of the prevailing charge, that charge may be increased by the greater of 1% or as follows:
>>
>>> January 1, 1987 - charge increases were limited to 1/4th of the difference between the actual charge and 115% of the Medicare prevailing charge;
>>>
>>> January 1, 1988 - charge increases were limited to 1/3rd of the difference between the actual charge and 115% of the Medicare prevailing charge;
>>>
>>> January 1, 1989 - charge increases are limited to 1/2 of the difference between the actual charge and 115% of the Medicare prevailing charge; and
>>>
>>> January 1, 1990 and subsequent years - actual charges may be increased to 115% of the Medicare prevailing charge.

OBRA-86 reduced prevailing charge levels for cataract surgery by 10% in 1987 plus another 2% in 1988. A limit of 4 base units for anesthesia services related to cataract surgery also was set. Special limits on fees for these services also were imposed, with actual charges limited to 1/2 the amount by which the charge exceeds 125% of the new prevailing charge in 1987 and to 125% of the prevailing charge in 1988 and thereafter.

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) made further substantial modifications in Medicare payment for physicians' services:

Three-Month Freeze - Prevailing and customary charge levels were maintained at the levels in effect during 1987 during the three-month period ending on March 31, 1988. Also during this three-month period, MAACs were kept at the amount determined for 1987. 1988 MAACs did not go into effect until April 1, 1988.

Sequestration - The Gramm-Rudman-Hollings sequestration reduced payments for physicians' services by 2.324% through March 1988.

Medicare Economic Index (MEI) - For services provided by participating physicians after March 31, 1988, the MEI increase was limited to 3.6% for primary care services and 1% for other physicians' services. Increases for the services of non-participating physicians were set at 0.5% less than the increase allowed participating physicians (3.1% and 0.5%). For physicians' services furnished in 1989, the increase for participating physicians is to be 3% for primary care services and 1% for other physicians' services. The increase in 1989 for non-participating physicians will be 0.5% less.

Reductions in Prevailing Charge Levels - The following physicians' services provided after March 31, 1988 were subjected to "reasonable charge" reductions: bronchoscopy (Codes 31622-31626), carpal tunnel repair (Code 64721), cataract surgery (Codes 66830-66985), coronary artery bypass surgery (Codes 33510-33528), knee arthroscopy (Codes 29880-29881), diagnostic and/or therapeutic dilation and curettage (Code 58120), knee arthroplasty (Codes 27446-27447), pacemaker implantation (Codes 33206-33208), total hip replacement (Codes 27130-27132), suprapubic prostatectomy (Code 55821), transuretheral resection of the prostate (Code 52601), and upper gastrointestinal endoscopy (Codes 43235-43239). The 1987 prevailing charge levels for these services initially were reduced by 2%. Further reductions of up to 15% were implemented according to a sliding scale formula for services between 85% and 150% of the national average.

Where a non-participating physician's allowed charge is reduced by the application of this provision (or for cataract procedures, or physician supervision of certified registered nurse-anesthetists), the physician may not charge the beneficiary more than 125% of the reduced allowed amount plus one-half of the amount by which the physician's MAAC for the service for the previous 12-month period exceeds the 125% level. In subsequent years, the maximum allowed charge will be set at 125% of the prevailing charge. Where a physician "knowingly and willfully" imposes a charge in violation of this provision, the Secretary is authorized to apply sanctions (civil money penalties, assessments, and five-year barring) against the physician. These charge reductions will not apply to services furnished after the earlier of December 31, 1990 or one year after the Secretary reports to Congress on development of the RVS.

Payment for Physician Anesthesia Services - In determining the amount allowed for the medical direction of two or more nurse anesthetists (in which services are provided in whole or in part concurrently) for services provided after March 31, 1988 and prior to January 1, 1991, the number of base units recognized for the medical direction (other than for cataract surgery or an iridectomy) will be reduced from current levels by: 10% where the medical direction is of two nurse anesthetists concurrently; 25% where the medical direction is of three nurse anesthetists concurrently; and 40% where the medical direction is of four nurse anesthetists concurrently. Where the anesthesia services are for concurrent cataract surgery or an iridectomy procedure provided after December 31, 1989 and before January 1, 1991, the number of base units that will be recognized for the medical direction will be reduced from current levels by 10%.

Fee Schedules for Radiologist Services - Medicare payments for radiologist services will be the lesser of 80% of the actual charge for the service or the amount provided under a fee schedule. "Radiologist services" are defined to include radiologic services performed by, or under the direction or supervision of, a physician who is certified or eligible to be certified by the American Board of Radiology, or a physician for whom radiologic services account for at least 50% of his or her Medicare billings.

Radiology Charge Limitations - Where radiologist services are provided by non-participating physicians or suppliers after 1988 and where payment is made pursuant to the fee schedule, the maximum amount that may be billed will be subject to a "limiting charge." The limiting charge will apply as follows: in 1989 - 125% of the amount specified in the fee schedule; in 1990 - 120% of the amount specified in the fee schedule; and after 1990 - 115% of the amount specified in the fee schedule. Where a charge is "knowingly and willfully" imposed above the limiting charge, sanctions may be applied

Limits on Payment for Ophthalmic Ultrasound - Effective for services provided after March 31, 1988, the prevailing charge level for A-mode ophthalmic ultrasound procedures may not exceed 5% of the prevailing charge level established for extracapsular cataract removal with lens implantation. Limits on actual charges for this service also apply.

Customary Charges for Services of New Physicians - For physicians who do not have adequate actual charge data, customary charges are to be set at 80% of the prevailing charge for the service in the area. (Previously, these charges were set at the 50th percentile of customary charges in the area, an amount usually above prevailing charge levels.) This limit is not applicable for primary care services or for services provided in designated rural areas.

December 15, 1988

PRESIDENT REAGAN'S FISCAL YEAR 1990 MEDICARE BUDGET PROPOSALS

The following pages set out the Medicare proposals contained in President Reagan's FY90 budget and the AMA's position on those proposals that are described in sufficient detail in the budget.

The Reagan Administration's federal budget for fiscal year (FY) 1990 requests $424 billion in outlays for the Department of Health and Human Services. This amount represents an increase in total outlays of almost $23 billion (5.7%) compared to current estimates for FY89. The largest component of the HHS budget is for Social Security outlays of $244 billion (an increase of about $14 billion, 6.2%, over estimated FY89 outlays).

The budget proposes nearly $3.5 billion in Medicare savings. Including these proposed savings, the projected outlays for the Medicare program are $94.9 billion (an increase of $8.1 billion, 10%, over the estimated FY89 outlays).

During the 1980s, the Medicare program has been subjected to numerous, arbitrary spending cuts. The AMA continues to be concerned that such cuts threaten the access to and quality of care for Medicare beneficiaries. The AMA opposes any additional arbitrary reductions in either Medicare Part A or Part B. In addition, the AMA continues to support certain revenue-enhancing proposals, including raising the Part B premium to 35% of program costs and requiring all state and local government employees to pay Hospital Insurance taxes.

Specific Medicare proposals set out in the FY90 budget proposal and the Association's views concerning each are set forth below.

Medicare Part B Proposals

1. Part B Premium (Revenues of $617 million in FY90)

   The budget proposes to extend Part B premium rates to cover 25% of Part B program costs.

   Position: The AMA continues to support increases in the Part B premium to fund at least 35% of program costs, noting that the Part B premium originally was to cover half of the program expenses.

2. Physician Payment: Reduce Payment for Certain Overpriced Procedures (Savings of $100 million in FY90)

   The budget proposes a reduction of up to 12% for 12 surgical procedures previously subjected to legislative reductions or other procedures that the Secretary may identify as overpriced. The 12 procedures subjected to reductions are: bronchoscopy, carpal tunnel repair, cataract surgery, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

Position: The AMA opposes these arbitrary cuts. Also, Congress has created a specific mechanism (inherent reasonableness regulation authority) to respond to inappropriate payment levels. The Association believes that all payment issues should be considered as part of a larger picture, such as the resource based relative value study now under way.

3. Reduce Physician Payment for Radiology, Anesthesiology and Surgery (RAS) Services (Savings of $250 million in FY90)

The budget proposes a reduction of 8 percent in payment levels for radiology, anesthesiology and surgery services, beginning in 1990.

Position: Payment levels should be determined through an indemnity system based on a Resource-Based Relative Value Study. In opposing this provision, the Association points to its arbitrary nature and the fact that recent payment cuts for radiology and anesthesiology services as well as limited MEI updates for surgical services have not been subjected to any analysis as to the effect of these cuts and limits.

4. Freeze MEI for Physicians' Non-Primary Care Services (Savings of $375 million in FY90)

By law, the annual increase in prevailing charge levels for physicians' services is limited by the Medicare Economic Index (MEI). The budget proposes a three-year update policy under which there would be no MEI increase in prevailing charges for non-primary care services of physicians in 1990, and a 1% increase in each of the next two years. Prevailing charges for primary care services of physicians would be increased by the full MEI in each of those years.

Position: While the AMA recognizes that primary care services generally have been under-reimbursed by Medicare, the AMA supports full and equal MEI updates.

5. New Physician Customary Charges (Savings of $40 million in FY90)

The budget proposes to phase in increases in customary charges for new physicians over four years: 80 percent of prevailing charge levels for first year physicians; 85 percent for second year; 90 percent for third year; and 95 percent for fourth year.

Position: The AMA previously opposed setting new physicians' customary charges at 80% of prevailing charge levels. The AMA opposes this new proposal as it only exacerbates the inequity of Medicare customary charges not reflecting real charges or expenses.

Part A Provisions

1. Direct Medical Education (Savings of $120 million in Part A and $30 million in Part B in FY90)

The budget proposes that direct graduate medical education costs be limited to the cost- related to residents' salaries and fringe benefits and appropriately allocated overhead costs. Program costs such as classroom space and supervision by teaching physicians would not be reimbursed.

Position: The AMA supports Medicare continuing to reimburse its fair share of all appropriate direct medical education costs. Legitimate direct medical education expenses incurred for administration, physical plant, classroom space, and supervision by teaching physicians should not be ignored in determining the fair share of such expenses to be borne by Medicare. Separating the service from the education aspects of residency programs could disrupt the educational process.

2. Indirect Medical Education (Savings of $1.02 billion in FY90)

The budget would reduce the indirect medical education adjustment from 7.7% to 4.05% in FY90.

Position: The indirect medical education adjustment should not be reduced below 6.6% unless and until such a reduction can be justified by reliable statistical data and adequate assurances exist that such a reduction would not negatively affect the quality of care. The AMA is concerned over the impact on teaching hospitals of a significant cut in the indirect medical education adjustment.

3. Peer Review Organizations

The budget requests $290 million for the PRO program, a decrease of $5 million from the FY89 funding level.

Position: The AMA supports adequate funding for the PRO program, and the Association believes the funding level proposed is adequate.

4. Set the Prospective Payment System (PPS) Update at the Market Basket Minus 1.5 Percent (Savings of $625 million in FY90)

The budget proposes to set the PPS adjustment at 1.5% less than the full market basket. The FY 1990 market basket is currently estimated to be 4.7%.

Position: The AMA previously supported the concept in the original PPS law of allowing an annual increase of market basket plus 1%, with the 1% being for new technology. While the Association recognizes the need for savings from all sectors of the budget, the AMA cannot support an adjustment below the market basket based on the current economic condition of hospitals.

5. Reduce Capital Payments to Hospitals by an Additional 10 Percent (Savings of $620 million in FY90)

Current law provides for reductions of capital payments to hospitals under the PPS. From October 1, 1988 through September 30, 1989, payments for capital costs are reduced by 15 percent. This provision, however, expires after 1989. HCFA is proposing an extension of the FY89 payment rates and that capital payments be reduced by an additional 10 percent in FY90. Current law now requires that the Secretary incorporate payments for capital into PPS on a per-case basis, beginning in 1992.

Position: The AMA is concerned that inappropriate implementation of changes in capital reimbursement could have a severe negative impact on the ability of patients to receive needed medical services. Money not spent on capital improvements today could result in more expensive costs down the road. The AMA believes that any hospital capital cost proposal must be closely monitored to assure that institutions can properly provide needed services for patients, and that any such proposal must provide for an adequate transition to allow institutions to meet already committed capital cost obligations.

6. Include Under Medicare State and Local Employees Hired Before March 31, 1986 (Revenue Increase of $2,027 million in FY90)

COBRA mandated Medicare coverage and payment of Hospital Insurance taxes for new state and local government employees hired after March 31, 1986. The budget proposes making Medicare coverage and Hospital Insurance taxes mandatory for all state and local employees, including those hired before March 31, 1986.

Position: The AMA supports this provision which is intended to bring about universal Medicare coverage.

APPENDIX III

MEDICARE PART B EXPENDITURES
ANALYSIS OF GROWTH

INTRODUCTION

Part B of Medicare covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. Disbursements for the Part B program have been the fastest growing non-defense expenditure item in the federal budget in this decade, having increased an average 16.3 percent annually between 1980 and 1987.

Even after inflation in medical care prices has been taken into account, total real disbursements increased at a 7.4 percent average annual rate. Growth in the enrolled Medicare population of 1.9 percent per year accounts for only a small amount of the real growth. The "residual" component of the inflation-adjusted growth that is not explained by beneficiary demographics (5.5 percent) is broadly attributed to increases in "volume" of services per eligible beneficiary and to increased "intensity" of services; i.e. more services per visit.

This report concerns that residual component of outlay growth not due to price inflation or enrollee increase, with special emphasis on the underlying factors responsible for the growth.

COMPONENTS OF PART B OUTLAYS

An accounting adjustment gives a truer picture of cost growth in the Part B program. The usual practice of focusing on cost per enrollee overstates the growth in "volume and intensity" when the proportion of enrollees who actually receive services is also growing. Analyzing costs on a per enrollee basis results in confusing the increased number of users as part of the increase in volume per enrollee. According to the General Accounting Office, the number of persons served per 1000 enrollees increased by about 16 percent between 1980 and 1986 (United States General Accounting Office, 1988). This means that growth in real outlays per service recipient was 3.0 percent per year.

To better understand the nature of Part B expenditures, it should be kept in mind that:

- physician services are about 60 percent of total Part B allowed charges;
- outpatient hospital department (OPD) services are about 28 percent of total allowed charges; and
- OPD allowed charges grew an average of 30 percent per year compared to 13 percent for physician services from 1980 to 1986.

These figures show that outpatient hospital services are a substantial component of the Part B program and contributed more to expenditure increases than physician services in recent years.

Center for Health Policy Research, American Medical Association, Chicago, Illinois, February, 1989

A recently completed study of Medicare claims data for five states for the years 1983 through 1985 reached the following conclusions (West _et al_., 1988):

- the major sources of growth in OPD services have been expanding use of OPD surgery and growth in the proportion of eligibles receiving services;
- the expanding use of OPD surgery has resulted in increasing the average allowed charge per service across all services, a common measure of "intensity;" and
- aggregate upcoding explains only a small percentage (4%) of the total increase in Part B allowed charges.

These findings suggest that the high rate of Part B expenditure growth is primarily confined to hospital outpatient departments, that patient demand has played a significant role, and that the extent of visit and procedure upcoding is far less than has previously been speculated by some analysts.

CAUSES OF INCREASED VOLUME AND INTENSITY

In the past year, research based on new sources of data has begun to replace speculation with documentation on the causes of Part B volume/intensity growth. Research findings fall into four broad areas:

- patient demand;
- technical innovations in outpatient services;
- third-party reimbursement practices; and
- trends in physician supply.

At a recent research conference on Part B volume growth held by the Leonard Davis Institute for Health Economics of the University of Pennsylvania and jointly sponsored by the AMA, there was much agreement among economists that the nature of volume increases evident in this new information is largely a manifestation of increases in patient demand. Demand effects may be broadly separated into two categories: factors that lower price to the patient at the point of service; and non-price factors that increase the amount of services demanded at a given price. Specific research findings include:

- Over the 1980-87 period, legislation raised the Part B deductible only once and increases in premiums were offset to a large extent by patient savings due to the increase in _assignment rates_ (United States General Accounting Office, 1988).

- The 40-month fee freeze of 1983-1987 allowed inflation to erode the real price of services, as has the subsequent MAAC program which has held fee increases below inflation.

- The prevalence of medigap insurance, which typically provides nearly first-dollar coverage, eliminates the constraints on unnecessary use intended to result from Medicare's cost-sharing provisions. As a result, use of Medicare-covered services is higher than it would otherwise be, and most of the costs of the additional services used are paid by Medicare rather than by medigap insurers. The effect of medigap coverage for the typical Medicare-not-Medicaid enrollee is to increase use of both physician and hospital services by about 24 percent. Over 80 percent of aged Medicare enrollees had either medigap insurance or Medicaid coverage in April 1984 (Christensen et al., 1987).

- As a group, the elderly are economically better off than the younger working-age population. In 1986, the average net worth of households with head of households between 65 and 74 years of age was $249,844, compared to $152,391 for households with head of household between 45 an 64, and $56,563 for households with head between 25 and 44. The greater wealth of elderly households would be expected to contribute to a greater demand for health care services.

- Medicare patients are becoming more aggresive consumers of medical care and more knowledgeable about the availability and benefits of new technology and procedures. For example, in the four months following President Reagan's cancer surgery in 1985, an estimated 73,000 additional colonoscopies were performed on Medicare patients (McMenamin, 1988).

- The biggest source of increase in approved charges per enrollee in recent years has come from outpatient surgery. The convenience of the outpatient setting significantly lowers the time price and the psychic cost to patients, affecting demand similar to a reduction in money price and resulting in a substantial net increase in the numbers of such procedures (West et al., 1988).

Improvements in the provision of medical services has proceeded apace on several fronts and are making the consumption of medical care easier, safer, and more accessible.

- Clinical innovations in outpatient procedures, as for example in cataract surgeries and endoscopies of the digestive system, have resulted in better products and allowing the physician to do more.

- As a result, outpatient services are in fact increasing the cost of U. S. health care in the private as well as public sectors; the Blue Cross and Blue Shield Association found that the number of outpatient visits per thousand people covered jumped 26 percent between 1981 and 1987 and the cost per visit rose 88 percent (Raynor, 1989).

- While the number of visits per person has remained relatively stable, the length of visits and the number and types of services provided has increased; specific examples are found in cardiology, thoracic surgery, gastroenterology, and ophthalmology. (Mitchell *et al*., 1988)

The insurance industry has been responsible for contributing to the shift to outpatient care. Most insurance companies reimburse 100 percent for outpatient care and 80 percent for inpatient care. (Blue Cross and Blue Shield, however, continues to reimburse 80 percent for procedures regardless of where they are performed.) It is natural for patients to seek out the lowest-cost care setting.

The increasing physician supply has resulted not only in increased access but a reduction in prices of physician services as evidenced by the increasing numbers of salaried physicians and increasing physician participation in PPOs and acceptance of discounted fee-for-service payment (Falk and Langwell, 1988).

PART A VERSUS PART B

Proposed federal budgets for both Part A and Part B were cut substantially by the successive budget reconciliation bills enacted during the 1980s. The sum of the budget savings estimated by HCFA for ORA, OBRA-81, TEFRA, DEFRA, COBRA, and OBRA-86 is approximately $18.2 billion for Part A and $13.4 billion for Part B (United States General Accounting Office, 1988). This represents a 6.9 percent reduction in cumulative Part A outlays and a 10.9 percent reduction in cumulative Part B outlays. Thus, relative to the respective program sizes, Part B was cut about one and one-half times more than Part A.

Nevertheless, Part A spending growth in the 1980s has been well below its trend in the 1970s; in contrast, Part B growth has been about the same. The hospital industry has clearly been affected by these Part A cuts, especially in rural areas. The cost-saving effects of the budget acts have been offset by increased utilization of Part B services: 40 percent for OPD services and 15 percent for physician and other Part B services.

CONCLUSION

In many ways, the growth in Part B outlays reflects the success of medicine in making available more and better care to the patient, which in turn has led to increased consumption of medical care:

- Improved techniques are making consumption of medical care easier, safer, and more accessible;
- Patients are being provided more and better information about the benefits of medical care, especially preventive services and procedures; and
- More options are being made available to patients, especially outpatient alternatives to inpatient procedures, affording them wider choice among alternative approaches to managing medical problems which they may choose based on personal, subjective criteria.

At the same time, erosion of the cost-sharing provisions of Part B has also resulted in increased growth in demand:

- Constraining fees by limiting MEI updates, freezing fees, and imposing MAACs has resulted in real growth in allowed charges per service below the rate of inflation;
- Medicare allowed charges are now less than 80 percent of physicians' usual fees; and
- The increasing prevalence of medigap insurance and acceptance of assignment neutralizes cost-sharing requirements.

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Adopted by the AMA House of Delegates,
December 6, 1988

REPORT OF THE BOARD OF TRUSTEES

Report: AA
(I-88)

Subject: The National Study of Resource-Based Relative Value Scales for Physician Services: Evaluation of Final Report of Phase I and Implementation Issues (Resolutions 88 and 127, A-88)

Presented by: John J. Ring, MD, Chairman

Referred to: Reference Committee A
(John C. Nelson, MD, Chairman)

At the 1988 Annual Meeting, the AMA House of Delegates adopted Board of Trustees Report OO. Report OO described criteria for evaluation of the Harvard study of resource-based relative value scales (RBRVSs) for physician services and recommended that a full evaluation of the study be conducted before any implementation decisions are made. Issues related to implementation of an RBRVS-based Medicare physician payment system were also reviewed in Report OO, and a policy recommendation supporting a transition period between the current Medicare physician payment system and any system involving payment schedules was adopted.

Resolutions 88 and 127 were also discussed at the 1988 Annual Meeting and were referred to the Board of Trustees for a report back to the House at this meeting. These resolutions called for the AMA to support development of a nationally uniform schedule of Medicare allowances that would provide the same level of reimbursement across all geographic areas of the country.

This report presents the results of the Board's evaluation of the Harvard study. It also provides an analysis of and recommendations for AMA policy on potential use of the RBRVS in a new Medicare physician payment system and related implementation issues. A discussion of geographic payment variations also responds to Resolutions 88 and 127.

This entire report reflects the deliberations of an Association Physician Payment Task Force, which was created to study these issues in depth. The Task Force consisted of two members each from the Board of

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Past House Action: A-88:134-140,140-144; I-87:28-32; A-87:52-56; I-86:106-109; A-86:137-140; I-85:97-99; A-85:162-164; I-84:65-66; A-84:352

Trustees, the Council on Medical Service, and the Council on Legislation. The Task Force:

- reviewed the Harvard RBRVS study and the issues related to its use in a new Medicare physician payment system;
- considered the views of the state, county, and national medical specialty societies, especially as presented at a meeting of the Federation convened on November 13; and
- reviewed results of an evaluation of the Harvard study conducted for the AMA by the Consolidated Consulting Group, Inc. (CCG), a Washington, D.C. consulting firm retained by the AMA to provide an independent assessment of the RBRVS study.

The findings of the Task Force were presented to the Board of Trustees and are reflected in the recommendations contained in this report.

BACKGROUND

The Harvard study was funded through a cooperative agreement with the Health Care Financing Administration (HCFA) in response to a congressional mandate to the secretary of Health and Human Services (HHS) to develop a relative value scale (RVS) based on the resource costs of providing physician services by July 1989. The study began in December 1985, and a 2000-page final report of the study was submitted to HCFA on September 28, 1988. Simultaneous with this report, the study's methods and results were published in the New England Journal of Medicine (NEJM), with an accompanying editorial by HCFA Administrator William Roper, MD. The October 28, 1988 issue of the Journal of the American Medical Association (JAMA) was devoted exclusively to the Harvard study, including a series of articles on its methods and findings and editorials by James S. Todd, MD, AMA senior deputy executive vice president; Philip R. Lee, MD, chairman of the Physician Payment Review Commission (PPRC); and Doctor Roper.

The development of an RVS is one of a growing list of Medicare physician payment reform efforts considered or enacted by the federal government. Faced with mounting budgetary pressures, the current Administration and Congress have considered implementation of physician diagnosis related groups (DRGs), widespread capitation, Medicare PPOs, expenditure caps, and further constraints on Medicare's current customary, prevailing, and reasonable (CPR) system. Revisions to CPR that have already been enacted include "inherent reasonableness" payment cuts for procedures deemed by Congress to be "overpriced" and implementation of Maximum Allowable Actual Charges (MAACs).

A series of status reports on the Harvard study (Board of Trustees Reports PP, I-88; D, I-87; M, A-87; Y, I-86; DD, A-86; DD, I-85; and ZZ, A-85) reviewed the rationale for the Association's involvement in the development of a Medicare RBRVS for physician services and described the AMA's role as a subcontractor in the Harvard study. ***The Board continues to believe that use of the Medicare Economic Index (MEI) to regulate prevailing charges, implementation of the Medicare Participating Physicians Program and MAACs, inherent reasonableness cuts, and a host of confusing, nonsystematic local carrier policies have made the CPR system untenable.***

The Board also believes that payment reform proposals such as volume and expenditure caps and widespread capitation are fraught with problems for both patients and physicians. If enacted, these proposals would undermine the independence of the medical profession and pose a serious threat to the clinical autonomy of physicians in making treatment decisions for their Medicare patients. Nevertheless, such proposals continue to be viewed favorably by some members of Congress and the current Administration, as evidenced, for example, by Doctor Roper's statements in his recent NEJM commentary on the RBRVS study:

> During the past 15 years, the Congress and several administrations have tried to control growth in Medicare spending for physicians' services in two ways. First, we have limited fees. . . Second, we have tried to slow the growth in spending on physicians' services by making capitation payments to private health plans. This approach has substantial potential for the long term, because capitation provides appropriate incentives to control both the price and quantity of services.
>
> (319:13, p. 867, 1988)

In contrast, Association policy argues that an indemnity payment schedule based on an appropriate RVS could be the basis for a more acceptable Medicare physician payment system that would preserve fee-for-service medicine, while eliminating much of the complexity that has progressively plagued CPR. The remainder of this report:

- presents a summary of the Board's recommendations (pp. 4-7);
- provides an overview of Harvard's final report to HCFA (pp. 7-9);
- presents the results of the Board's evaluation of the Harvard report (pp. 10-17);
- discusses issues related to implementation of the Harvard RBRVS in a Medicare payment system (pp. 17-39); and
- recommends adoption of a policy agenda to form the basis for AMA strategy on Medicare physician payment reform (pp. 39-43).

SUMMARY OF RECOMMENDATIONS

This is a comprehensive report, with a number of recommendations interspersed throughout it. Accordingly, to assist the reader in reviewing this report, its recommendations have been summarized below. The Board of Trustees is proposing that the following positions be adopted:

Relative Value Scale

1. That the AMA reaffirm its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using:

    a. an appropriate RVS based on the resource costs of providing physician services;
    b. an appropriate monetary conversion factor; and
    c. an appropriate set of conversion factor multipliers.

2. That the AMA adopt the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system.

3. That the AMA work with Harvard, the national medical specialty societies, the PPRC, HCFA, other interested and knowledgeable parties, and the Congress to refine and modify the Harvard RBRVS to ensure that it is technically adequate and can be implemented in a timely and minimally disruptive manner when needed revisions have been satisfactorily completed. Refinement and completion of the RBRVS will require:

    - appropriate restudy of the services of specialties whose RBRVS data have significant, documented technical deficiencies;
    - fundamental improvement of the measurement of practice costs and amortized specialty training costs;
    - expansion of the RBRVS to more specialties and services;
    - development of an extrapolation method for visits;
    - revision, refinement, and expansion of the measurement of pre- and post-work;
    - expansion and validation of the extrapolation methodology;
    - development of expanded relative value estimates for services for which global fees are customarily utilized as standard definitions are developed and accepted;
    - appropriate action to address concerns specific to individual specialties; and
    - that the AMA work to establish a mechanism to ensure that additional concerns that may be identified are communicated to and addressed by the appropriate parties and external validation is conducted by the AMA.

Balance Billing

4. That the Association reaffirm its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing.

5. That the AMA reaffirm its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

6. That the Association promote enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

7. That the Association expand its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

Transition

8. That a Medicare indemnity payment system be implemented through a blending transition, in which physician payments would be determined in increasing proportion by an RBRVS-based indemnity payment schedule and in decreasing proportion by the current CPR payment system, or prevailing charges only. The specific transition period should be chosen in order to strike an appropriate balance between minimizing disruptions for patients and physicians while also minimizing the complexity of the process. In addition, the effects of the new system should be monitored during the transition, with corrections made as needed.

Geographic Payment Variations

9. That the AMA reaffirm its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

10. That payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan/nonmetropolitan areas within states) based on the availability of high quality data.

11. That geographic differentials should be addressed simultaneously with specialty differentials.

12. That, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

Specialty Differentials

13. That the AMA support the general principle that an RBRVS-based payment schedule should include differentials in payment for CPT codes where there are differential resource costs ("total work" and practice and training costs) across specialties. The following criteria should guide the establishment of differentials for specific services:

    a. When the resource costs are substantially different across specialties; and

    b. When the relevant codes are not sufficiently precise to differentiate among the content or physician work of a service across specialties, and cannot be readily refined to become so.

    In addition, as few separate payment categories as possible should be established to minimize system complexity. In general, specialty differentials should be avoided except where absolutely warranted by resource cost data.

14. Specialty differentials should apply to all CPT-coded services for which a differential exists.

15. Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to:

    - Partial completion of a residency plus time in practice;
    - Local peer recognition; and
    - Carrier analysis of practice patterns.

    A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

Initial Conversion Factor

16. That the Association strongly oppose any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

Updating the Fee Schedule

17. That whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience, and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

Volume and Intensity

18. That the Association strongly oppose implementation of Medicare expenditure targets, which will lead to the rationing of care for Medicare beneficiaries, and instead support constructive approaches to enhancing quality and appropriateness of care.

19. That this report be adopted in lieu of Resolutions 88 and 127 (A-88).

I. OVERVIEW OF THE HARVARD RBRVS STUDY

An RVS is a list of physician services ranked according to "value" in nonmonetary units. The resource cost approach is one of at least five alternatives for developing an RVS. Others have argued that RVSs should be based on physicians' charges, patients' willingness-to-pay, negotiations, physicians' assessment of the worth of a procedure, or benefits to society. Most previous RVSs have been based on physicians' charges. The Harvard report argues that resource costs are a more appropriate basis for an RVS. Current AMA policy supports this view.

The initial effort to develop an RBRVS was conducted by Hsiao and Stason in 1979. This exploratory study assessed relative resource inputs for 27 services performed by five specialties. A second study was conducted by Hsiao and Braun in 1984. In both studies, physicians' ratings of work were consistent; however, the data were considered unreasonable by the investigators and their physician consultants.

The objectives of the national RBRVS study described in this report were:

- to develop RBRVSs for services provided by 18 specialties;*
- to combine the specialty-specific RBRVSs into a single, national cross-specialty RBRVS; and

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*HCFA initially funded an RBRVS for 12 specialties: anesthesiology, family practice, general surgery, internal medicine, obstetrics and gynecology, ophthalmology, orthopaedic surgery, otolaryngology, pathology, radiology, thoracic/cardiovascular surgery, and urology. Six additional specialties were funded independently and included in the study at their request: allergy and immunology, dermatology, oral and maxillofacial surgery, pediatrics, psychiatry, and rheumatology.

- to subject the methodology and results to review by experts in medicine, statistics, and health policy.

The Congress also mandated (in OBRA 1987) that the national RBRVS study be expanded to an additional 15 specialties.** Harvard has been funded by HCFA to extend their study to these additional specialties in a second phase to begin this winter.

Harvard's method for measuring resource costs focused on three basic inputs: (1) the work involved before, during and after providing a service; (2) relative specialty practice costs; and (3) the opportunity costs of specialty training. The work involved in the actual provision of a physician's service or performance of a procedure was termed intra-service work in the study. Work prior to and following provision of a service, such as surgical preparation time, writing records, or discussion with other physicians, is referred to as preand post-service work.

The total work involved in physician services is defined by Harvard as comprising time and intensity per unit time. Because the two previous efforts to develop an RBRVS had not succeeded in obtaining reliable measurements of intensity, this study began by attempting to identify the components of intensity and improve their measurement.

Interviews with 20 physicians and discussion with the 100 physician members of the study's 14 Technical Consulting Groups identified the following factors as determining the intensity of a service: (1) mental effort and judgment; (2) technical skill; (3) physical effort; and (4) psychological stress. In order to measure total work, the investigators developed a national survey in which sampled physicians were asked to rate the total work as well as to separately rate time and the four dimensions of intensity for 22 services provided by their specialty. These services were presented to surveyed physicians in the form of brief descriptive vignettes. For example, one of the thoracic surgery procedures was described to physicians as:

> *Permanent single chamber cardiac pacemaker implantation with single transvenous electrode insertion into ventricle in 70 year old female with bradyarrythmia, no acute MI or significant co-morbidity.*

To further improve measurement of total work over the earlier studies, the national survey incorporated the technique of "magnitude estimation," a method designed to measure subjective perceptions and judgments. Physicians were asked to use a particular service as a standard, and then rate the total intra-service work of all the other surveyed services in comparison to that of the standard. For example, since the standard was

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**The 15 new specialties to be included in the second phase of the Harvard RBRVS study are: cardiology, emergency medicine, gastroenterology, hematology, infectious disease, nephrology, neurology, neurosurgery, nuclear medicine, oncology, physical medicine and rehabilitation, plastic surgery, pulmonary medicine, radiation oncology, and physicians who specialize in osteopathic procedures.

assigned a value of 100, physicians would be instructed to assign a value of 200 to a service involving twice as much work and a value of 50 for one involving half as much work. The results of this national survey of work served as the primary data for constructing the RBRVS. The magnitude estimation method was used to assess total work and each of the components of intensity, whereas physicians were asked the actual time in minutes required to deliver each service. **Physicians' direct composite measures of total intra-service work, rather than the individual components, were used to construct the RBRVS.**

Cross-specialty links were identified by physician consultant groups and used in a statistical technique that placed the specialty-specific work estimates on a common scale of total work. The relative values were then multiplied by indices of practice costs and specialty training "opportunity costs". Finally, the relative values developed for the surveyed procedures were extrapolated to other services in the same CPT code category according to body system, anatomic part, and type of procedure. Extrapolation to these "families" of closely related coded services was based on Medicare and other third-party payor charges.

To provide guidance on the study methodology and medical practice, the study organized 14 Technical Consulting Groups (TCGs), comprised of representatives from the 23 specialties of the American Board of Medical Specialties, six subspecialties of internal medicine, and oral and maxillofacial surgery. The TCGs were asked to comment on the study methodology, assist in selection of services for inclusion in the national survey of total work, and review the reasonableness and validity of the study data. The AMA, in consultation with the national medical specialty societies, nominated two to three physicians for each TCG slot, and the Harvard team then selected from among these nominees. Each of the TCGs met in June 1986 and during the summer of 1987. An additional 34 physicians, drawn primarily from the TCGs, were selected to form a Cross Specialty Consultative Panel, which met three times to address issues and questions related to the cross-specialty linkage process.

The AMA has been a subcontractor to Harvard since 1986, and will continue as a subcontractor in the second phase of the study. The AMA worked to ensure that the experiences of practicing physicians were accurately reflected in the study by:

- furnishing advice on the study's methods:
- working with the national specialty societies to secure physician nominations for the TCGs and the study's March 1988 National Consultative Conference;
- providing data on practice costs and patterns from the AMA Socioeconomic Monitoring System; and
- supplying a nationally representative sample of physicians from the AMA Physician Masterfile.

II. EVALUATION OF THE RBRVS STUDY

The discussion below presents the major findings and conclusions of the Board's evaluation of the Harvard study. This review reflects, as appropriate, the *CCG's* report on the RBRVS study. A *"Technical Appendix" to this report (pp. 44-60) provides a more detailed overview of this evaluation.* The acceptability of the study's results for use in a Medicare payment system is addressed in Section III of this report.

Measurement of Intra-service Work

Evaluation of the survey of intra-service work suggests that this component of the RBRVS study was well-designed and that the investigators used appropriate statistical tests to assess the reliability and validity of their results. The method used to determine sample size requirements was appropriate. Statistical tests that are reported strongly suggest that the sample responses were representative of the general population of physicians. Findings from the survey were demonstrated to be consistent and reproducible.

The *CCG's* assessment found that this component of the study was successful in measuring physicians' intra-service work, and that appropriate statistical tests were used with "generally excellent" results. The *CCG* also performed a separate test to determine if Harvard's results for representative specialties simply mirrored existing charge structures, and found that this was not the case.

The weakest portion of the study, as reported, is the lack of external validity checks, that is, comparison of the survey results with other measures of resource costs. In this regard, the comments of the TCG physicians, who provided the strongest check on the how well the survey results reflected clinical practice, do not receive sufficient attention in the study's final report. More detailed discussion of the TCG's reactions to the survey findings in the Harvard report might have provided more evidence on the validity of this measure of intra-service work.

In addition, it is clear that the study would have benefited from more timely provision of information to TCG physicians, as well as a greater responsiveness to some of their expressed concerns. AMA staff will work to ensure that use of the TCGs during the second phase of the study is improved to respond to these deficiencies.

Cross-Specialty Analysis

The study's approach to linking the specialty-specific RBRVSs on a common scale appears to be methodologically sound and to have produced generally valid results. This view is supported by statistical tests performed by the investigators, as well as the *CCG*'s analysis. In addition, all of the linking services were required to pass the scrutiny of either the TCGs, the cross-specialty panel, the survey respondents, or a combination of the three groups, which provides a strong indication that they were, in general, appropriately selected.

Still, it would have been highly desirable to have had considerably more in-depth TCG review of final cross-linked relative values. In addition, a few specialties were weakly linked and require further study. Finally, additional analyses of the statistical methodology should also be conducted.

Pre- and Post-Service Time and Work

Review of this component suggests that additional work is needed to refine and validate the methods used. The *CCG* reports that, although the study made sophisticated use of limited data, these data are less reliable than the results for intra-service work. Reported pre- and post-times from the study's two separate surveys differed substantially, and sample sizes for some specialties in the second survey were small. Also, analysis of the statistical method used to estimate pre- and post-work indicates that there could be significant errors in these data.

The investigators admit to imprecision in the estimates of pre- and post-work as a result of combining survey data, predicted estimates, and secondary data; however, they suggest that the relative nature of an RVS would minimize the impact of unsystematic biases, and that moderate inaccuracies in pre- and post-work would not have a large impact on total work. Nevertheless, because pre- and post-work accounted for a substantial percentage of total work, ranging between 30 percent and 50 percent for most of the studied services, it is essential that better data on this component of work be collected and that the methods used to estimate pre- and post-work be validated and refined.

Extrapolation to Nonsurveyed Services

Harvard's statistical analysis of their charge-based extrapolation method suggested that grouping services into closely related groups of services improved the ability of charges to predict work values. After completing its extrapolations, Harvard created a physician review committee to review these results. Because of the difficulties of using small groups of reviewers to pass judgment on market-generated data representing the experience of many physicians, Harvard deliberately adopted a strict criterion for identifying "unreasonable" estimates.

Review by this physician panel suggested that Harvard's extrapolation methodology and results were generally (85%) reasonable for most types of service. Fewer than 15% of the extrapolated services were found to be clear outliers. In addition, due to rank order anomalies (e.g., extended visit charge lower than intermediate visit charge) and the compression of charge data for visits relative to physician work, the Harvard investigators concluded that the charge-based extrapolation methodology could not be applied to evaluation and management services.

The basic concept of using charge ratios within closely related categories of CPT-coded services to extend the RBRVS to non-surveyed services is the best method available for achieving this purpose. Nevertheless, evaluation of this component of the study raises a number of concerns:

- Although the investigators attribute problems in extrapolating to evaluation and management services to variations in coding practices between specialties, only limited evidence is presented that would support this view.

- The use of national frequency-weighted average Medicare charges can lead to anomalies and/or compression in relative values that probably would not occur in individual charge localities.

- By selecting vignettes for the survey of intra-service work prior to identifying the CPT families for which relative values were required, a number of families did not contain any surveyed services while others contained more than one. One result of this approach is that the RBRVS represents the range of services provided by some specialties better than others.

The investigators need to refine their development and use of vignettes for evaluation and management services. They also must explore other data available for extrapolation, and may need to survey for additional evaluation and management services. Also, the AMA Ad Hoc Committee on Visits and Levels of Service is working with HCFA, the PPRC, and Harvard to explore refinements in CPT codes for these services to make them better suited to measuring differences in work while remaining clinically meaningful.

Finally, as the *CCG's* report suggests, a more systematic review process by broader groups of physicians within the affected specialties will be needed to evaluate extrapolated values. In particular, there must be a mechanism to not only identify potentially erroneous distortions but to revise relative values in a credible manner. The AMA has a clear leadership role to play in this process.

Relative Practice Cost Differences Among Physician Specialties

The Harvard methods and data used to measure and allocate practice costs across the surveyed specialties are severely flawed and will have little influence on any final RBRVS that might be used by Medicare. The final report of the study identifies several problems with the methodology and the data used in calculating the practice cost factor (which for most specialties fell within a 15% range), including:

- the Physician Practice Cost and Income Survey (PPCIS) data used were from 1983;

- the sample sizes for some of the specialties in the PPCIS were extremely small;

- the ratios of practice costs to income are based on income under the current payment system, so that the change to an RBRVS-based fee schedule would likely alter the appropriate ratios; and

- the method of allocating costs across all specialty services does not distinguish between services provided in office settings and in non-office settings.

The *CCG's* review states that these problems increase the probability of "significant inaccuracies." In particular, the use of practice cost ratios based on current specialty incomes introduces significant distortions. For example, if the distributional effects of an RBRVS-based fee schedule were such that revenues for a specialty would be cut substantially and a practice cost ratio based on income prior to the revenue cut was used, the specialty's revenue loss could be seriously exaggerated.

Clearly a final RBRVS must accurately incorporate practice costs. Given time and budget constraints, Harvard devoted most of its time and resources to estimating the work component of an RBRVS. The PPRC has announced its intention to develop an entirely new practice cost component for an RBRVS. The PPRC's work is likely to focus on the ratio of specialty practice costs to total work rather than income, to treat professional liability insurance separately from other costs, and to attempt to allocate practice costs across the services provided by each specialty in a more accurate manner. The Harvard data on work, if sufficiently refined and validated, could be readily combined with an improved practice cost component in a final RBRVS.

Measurement of the Amortized Opportunity Costs of Specialty Training

This component of the study had a relatively small effect on total work. Using general surgery as the standard, the training cost factor for internal medicine was 1% less than general surgery and for thoracic surgery was 5% percent more than general surgery. A weakness that this component of the study shares with the practice cost component is its reliance on current specialty income levels. In one sense, the effect of maintaining these current relative incomes is greater in the opportunity cost component, however, because it is based on lifetime earnings. On the other hand, since the amortized costs of specialty training represent a much smaller proportion of physicians' annual incomes than the 50% accounted for by practice costs, the net effect of basing this factor on current incomes is small.

Study Results

Major findings from the study include:

- The intensity of physicians' services varies widely across services. Work per minute ranges from a low of 1.4 to a high of 19.4, with average work per minute for evaluation and management services less than half that of invasive services. There is more variation in work per minute for invasive procedures than for other types of service.

- Physicians' work prior to and following the actual provision of a service (pre- and post-work) comprises a substantial portion of total work, from an average of 33% for evaluation and management services to 50% for invasive services.

- Although estimated resource cost values for invasive procedures are strongly correlated with submitted charges for these services, the wide range in ratios of Medicare charges to relative values for invasive procedures, from 0.42 to 2.32, suggests that relative Medicare charges do not accurately reflect relative resource costs for individual services.

- The RBRVS suggests that visits should be valued more closely to invasive services than they are by Medicare submitted charges. The study demonstrated that the relationship between visits and non-visits was derived from within-specialty survey results rather than the cross-specialty linking process. Because of the inability to extrapolate for evaluation and management services, however, it is difficult to define the exact visit values with precision.

The investigators cite a number of limitations of the study in their final report:

- The RBRVS does not take into account differences in patient severity, quality of care, benefits of care, or patient demand.

- The study methodology could not reliably extrapolate relative values for non-surveyed evaluation and management services.

- The RBRVS does not provide values for surgical services billed globally, defined as those for which post-operative office visits are included with the operation in one charge. The RBRVS can be used, however, to build global relative values given specific global "packages."

- The study only incorporated inter-specialty differences in practice costs, but did not account for differences in practice costs between services provided by the same specialty.

To address some of these limitations, the investigators recommended that additional research be conducted to expand the RBRVS to include non-surveyed specialties and all of the most frequently performed Medicare services, to develop a better extrapolation method for evaluation and management services, and to complete the RBRVSs for psychiatry and anesthesiology, which are described as tentative.

Conclusions of Evaluation

Evaluation of the Harvard RBRVS final report reveals that the study has a number of strengths, but also some serious weaknesses. The conclusions of the *CCG's* assessment of the study are as follows:

> *The RBRVS study's major effort -- the measurement of physicians' "intra-service" work (i.e., the work needed to perform specific services and procedures) -- was successful. The RBRVS researchers designed and conducted pilot and national surveys of physicians about this work and its components. They obtained generally accurate,*

> *reliable and consistent rankings of relative work from each of 18 specialties for about 22 representative services. These separate specialty-specific rankings were also successfully linked into a common scale. These results show that it is feasible to develop a work scale built on physicians' views about their work. Such a scale represents the foundation for a complete RBRVS scale.*
>
> *As the RBRVS study moved beyond national survey-based work estimates to assess other resource costs, the researchers had to use less reliable data and rely more upon complex estimating techniques and extrapolation methods. Key difficulties proved to be inadequacies in the federal government's data on physicians' practice costs, work measurement and data for extrapolation of the CPT-4 visit codes, verification of extrapolation methods, and limited data on pre- and post-service work effort.*

The Board concurs that the results of the analyses of physicians' work and the cross-specialty alignment process, which were the primary data used to develop the RBRVS, were the strongest from a methodological perspective. The investigators have given considerable attention to the size and representativeness of their samples. The data that have been produced on the work involved in physician services have passed appropriate statistical tests of reliability and validity as well as the scrutiny of practicing physicians. The method that has been developed for assessing work has been demonstrated to obtain reproducible results and to accurately measure total work and its components. The basic relationships between services that were identified in the specialty-specific surveys, such as the ratings for visits relative to non-visits, were maintained and confirmed by the cross-linking process.

The extrapolation methodology may also be regarded as a strength of the study, although it is not as well validated. For the majority of services within the families of codes surveyed by Harvard, physician reviewers found that the charge-based extrapolation method produced relative values that approximated relative resource costs.

There are three major weaknesses in the study methodology: the treatment of relative specialty practice costs, the inability to extrapolate for non-surveyed evaluation and management services, and the lack of validation of the pre- and post-work estimates. In addition, as the study report suggests, additional work is required to develop relative values for a greater number of services in some specialties, and there needs to be more attention given to global billing and completion of the RBRVS for anesthesiology and psychiatry.

A more systematic review process by broader groups of physicians within the affected specialties will be needed to evaluate extrapolated values. In particular, there must be a mechanism to not only identify potentially erroneous distortions but to revise relative values in a credible manner. The AMA has a clear leadership role to play in this process.

In addressing the question of whether the study accomplished its goals, the answer is affirmative for some goals and negative for others. The study did succeed in developing a methodology for measuring the relative work involved in physician services, but, because of the problems with the practice cost factor, did not adequately measure all of the resource costs of physician services. The relative values of work can therefore be accepted as generally valid, but not the overall RBRVS. In addition, because of the limited number of surveyed evaluation and management services and the incomplete scales for psychiatry and anesthesiology, the study remains to some degree incomplete.

The weaknesses and limitations outlined in the study's final report and in this evaluation can all be categorized as areas in need of further attention. They do not represent intractable problems. Additional study can produce a more appropriate measure of relative specialty practice costs, a more refined method of measuring pre- and post-work, and a more comprehensive RBRVS. With sufficient resources, this work could permit timely completion and implementation of an RBRVS based on the Harvard data.

The Harvard study has to date succeeded in developing a valid methodology for measuring relative physician work and has produced an initial scale of resource-based relative values for most of the services provided by 18 specialties. The appropriateness of the study's results as the basis for a new Medicare physician payment system will be discussed below. **Nevertheless, the Board of Trustees remains committed to the development of a complete, refined RBRVS for physician services.** Refinement and completion of the RBRVS will require:

- Improvement of the Measurement of Practice Costs

  The PPRC has taken the lead in this area and has already made considerable progress toward addressing the major concerns raised in this evaluation, including use of high quality data and ratios of costs to total work rather than current income. The AMA will furnish its data and expertise to aid this effort.

- Expansion of the RBRVS to More Specialties and Services

  A more comprehensive RBRVS is the major goal of the second phase of the Harvard study, which is already underway. This second phase will expand the study to 15 additional specialties, survey additional services for general and orthopaedic surgery and for internal medicine, and, if necessary, survey additional evaluation and management services provided by specialties surveyed in the first phase.

- Development of an Extrapolation Method for Visits

  Since problems in this area stem from several factors, including the wording of vignettes, their relationship to CPT codes, and distortions in use of national charge data, they must be addressed on several fronts. The AMA Ad Hoc Committee on Visits and Levels of Service is working with HCFA, the PPRC, and Harvard to address problems in the use of current CPT visit codes for defining physician work in the RBRVS study. In the second phase of the study, Harvard will need to provide more information relevant to physician work and coding in its descriptive vignettes and explore alternative extrapolation methods.

- Refinement of the Measurement of Pre- and Post-Work

  The second phase of the Harvard study offers an opportunity to validate the reliability of the method used in Harvard's second survey of pre- and post-time, and to develop and validate a more logical approach to assigning work per unit of time values. Presumably, the complex, multi-layered approach used in the first phase was a result of unanticipated findings regarding pre- and post-work. These findings should assist in refining methods in the second phase.

- Expansion and Validation of the Extrapolation Methodology

  The process of selecting vignettes/codes to be surveyed in the first phase of the study provided insufficient data to validate the charge-based extrapolation method. Obtaining such data should be an explicit objective in the second phase. The AMA will play a leadership role in ensuring more systematic review by broader groups of physicians to evaluate extrapolated values. In addition, a method should be developed to expand the RBRVS to those families of CPT codes that do not contain a surveyed service.

- Continuation of Evaluation and External Validation

  The AMA and members of the Federation will continue to evaluate the final report of Harvard's first phase and may identify additional technical concerns. The AMA evaluation has focused on general issues regarding the technical adequacy and validity of the Harvard RBRVS. In addition, several specialties have identified problems and questions relating to their particular experience. The AMA will work to help these specialties resolve these difficulties. In particular, AMA evaluation activities will focus on verifying that the complete and expanded RBRVS, to be forthcoming pending completion of the preceeding steps by Harvard, the PPRC, and HCFA, accurately reflects all components of the relative resource costs of physician services, both as physicians perceive them and as objective measures demonstrate. The AMA will work to establish a process that ensures that (1) additional concerns that may be identified are communicated to and addressed by the appropriate parties, and (2) external validation is conducted.

III. IMPLEMENTATION ISSUES

A critical issue in evaluating the RBRVS study is the acceptability of the study's results as the basis for a Medicare physician payment system. Report OO identified promotion of common perspectives within medicine as the primary criterion for evaluating RVS implementation issues. In particular, the major question to be addressed in assessing these implementation issues is the potential for an RVS-based system, relative to other physician payment reform proposals, to cause disruption in the delivery of physician services to Medicare patients.

Although an RVS establishes the value of physician services relative to one another, the design of a new payment system incorporates a number of other important components. The five most pressing policy questions that require resolution before an RVS can be transformed into a Medicare physician payment system are:

- Does the Harvard RBRVS provide an acceptable basis for a Medicare schedule of allowances?
- How can balance billing be preserved under an RVS-based Medicare physician payment system?
- What form of incremental implementation of a new Medicare physician payment system should the AMA support in order to enable as smooth a transition as possible to a new payment system?
- How should geographic practice cost variations be treated in a new Medicare physician payment system?
- Should different payments be made to different specialists for services designated by the same CPT code, and, if so, on what basis?

The sections that follow address each of these questions. They include background on each issue, discussion of major policy options available to the AMA, and policy recommendations. Brief discussions and recommendations regarding other issues in the implementation of a fee schedule, including the first-year monetary conversion factor, updating the conversion factor and the relative values, and potential pressures for new volume controls, are also provided for the House's consideration.

RELATIVE VALUE SCALE

The AMA has viewed an RBRVS as an integral element of a new Medicare indemnity payment system. The AMA has been a subcontractor to Harvard, and has supported the project without committing to endorse the RBRVS or its implementation. The Board of Trustees continues to view an indemnity payment schedule as the most promising and likely of the alternative methods of paying for physicians' services under Medicare.

A fee schedule is a listing of the specific amounts payable for individual services provided by physicians. Thus, each service or procedure is associated with a specific dollar amount. A fee schedule is based on an RVS and a monetary conversion factor.

The Physician Payment Review Commission (PPRC) has recommended a fee schedule using an RBRVS, but not specifically the Harvard RBRVS. The commission intends to recommend such an RBRVS, probably based on the basic Harvard RBRVS data, in its March 1989 report to Congress. The PPRC is committed to evaluating the RBRVS and refining it where necessary through new methods, data, and consensus groups. Some commissioners have stated that this refinement process should include consideration of moderating physician gains and losses, as well as extreme changes in beneficiary liability.

HCFA has a congressional mandate to develop its own RBRVS by July 1989. HCFA funded the Harvard RBRVS study as a means of fulfilling this mandate but has discretion to refine the Harvard RBRVS for its own purposes. The second phase of the Harvard study, which is underway, will extend the RBRVS from the original 18 specialties to an additional 15 specialties by the end of 1989.

Congress has looked favorably upon the RBRVS/fee schedule approach to physician payment. Mounting congressional pressures since 1983 to "reform" Medicare Part B physician payment have been partially held in check by the promise of the RBRVS. In testimony to the Congress, Administration, and PPRC over the past three years, the AMA has held out the promise of an RBRVS to argue against such undesirable policies as physician DRGs. As an initial RBRVS is completed, Congress may view this area with renewed impatience, especially given continued growth in Medicare Part B expenditures. It appears likely that Congress will enact legislation in 1989 or 1990 directing initial implementation of an RVS-based fee schedule for 1991 or 1992.

The Board's assessment of the Harvard RBRVS study suggests that it was well conducted, with data on physician work of generally high quality. Nevertheless, several important areas have been identified as requiring completion or refinement prior to any implementation. ***The current RBRVS data, with sufficient attention to this needed work, could provide a basis for a Medicare indemnity payment schedule.***

The Board has considered the potential impact of a fee schedule based on the Harvard RBRVS on physicians and their Medicare patients. AMA simulations of an RBRVS implementation that would leave the Medicare budget for physician services unchanged during a year of total implementation indicate that under such a budgetary constraint, and even with the RBRVS as currently constituted (including the current flawed practice cost index and questionable visit extrapolations), **more than 50% of physicians would gain and 75% of physicians would either lose less than $1,000 or gain.** Such an implementation scenario predicts a major gain for those specialties and physicians whose work is predominantly composed of visits and consultations: family practitioners' average Medicare revenues increase by 65% and internists' by 24%. Those specialties and physicians whose work is largely composed of procedures would face cuts, in some instances potentially severe cuts, in their average Medicare revenues under this scenario: ophthalmologists' and thoracic surgeons' Medicare revenues decline by 39%, urologists' by 5%, and general surgeons' by 19%.

These preliminary simulations of the impact of an RBRVS fee schedule do not reflect probable revisions in the RBRVS by the PPRC and Congress, the likelihood that a transition period would moderate annual gains and losses, and normal changes in utilization patterns. In addition to improving the technical adequacy of the RBRVS, revisions by the PPRC and Congress could also focus on minimizing disruptions for Medicare beneficiaries and their physicians.

For example, the AMA simulations using the current RBRVS show that the imposition of the "no change" budget constraint increases the portion of the Medicare budget that is spent on visits by 66% (and funds this increase by cuts in expenditures for non-visit services of roughly 30%, without the vast majority of such services being "overvalued" by any objective criterion). Current Medicare allowed charges represent an average of a 27% reduction from submitted charges. The Congress may be resistant to increases for visit payments that are substantially above either submitted or non-Medicare charges. In addition, a substantial decrease in payments for non-visit services could raise access concerns for Medicare patients.

The PPRC and Congress are seeking to implement reforms in physician payment that will produce predictable effects for beneficiaries and the federal budget. Sharp changes in revenues for some specialties could make such predictability difficult. Finally, the PPRC's work in revising the practice cost component of the RBRVS could substantially alter the impact of an RBRVS-based fee schedule on specialties, as could inclusion of global relative values for surgical procedures. *Thus, many of the largest visit payment increases and non-visit decreases indicated by simulations of the current "budget neutral" scenario might not occur.*

Nevertheless, one of the strongest findings from the Harvard study and similar research is that the gap between visits and procedures under current Medicare charge patterns is too large according to a resource cost criterion. This finding can be obtained by examining within-specialty estimates of total work provided by procedural specialties as much as through comparisons between procedural and non-procedural specialties.

On the other hand, although the Harvard data demonstrate that the gap between payments for visits and procedures should be reduced, considerable uncertainty remains about the exact degree and manner in which the gap should be lessened. Similarly, uncertainty about the precision of the relative value estimates for individual services and procedures may lead the PPRC and the Congress to exercise caution in imposing severe payment cuts on these procedures. *Likely modifications to the RBRVS could therefore moderate specialty losses while still providing significant gains for those specialties that provide predominantly visit services.*

The Board has considered other approaches to developing an RVS as the basis for a Medicare payment system. The principal alternative that has been offered is development of a charge-based RVS. The charge-based approach has been used in the California RVS and the Florida RVS, and has been endorsed by the American College of Surgeons. Fundamentally, a charge-based RVS would preserve many of the distortions of the CPR system. Support for a charge-based RVS/fee schedule would also repudiate basic Association policy and activities over the past four years and would undermine AMA credibility. Such a system could have been developed several years ago, but the AMA urged Congress to wait for an RBRVS. In addition, the charge-based approach has been rejected by the PPRC and several key congressional committees. The Board has also concluded that incorporating patient severity, quality of care, benefits of care, or patient demand into an RBRVS or any RVS is not technically feasible at this time.

Recommendation

1. That the AMA reaffirm its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using:

   a. an appropriate RVS based on the resource costs of providing physician services;
   b. an appropriate monetary conversion factor; and
   c. an appropriate set of conversion factor multipliers.

2. That the AMA adopt the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system.

3. That the AMA work with Harvard, the national medical specialty societies, the PPRC, HCFA, other interested and knowledgeable parties, and the Congress to refine and modify the Harvard RBRVS to ensure that it is technically adequate and can be implemented in a timely and minimally disruptive manner when needed revisions have been satisfactorily completed. Refinement and completion of the RBRVS will require:

   - appropriate restudy of the services of specialties whose RBRVS data have significant, documented technical deficiencies;
   - fundamental improvement of the measurement of practice costs and amortized specialty training costs;
   - expansion of the RBRVS to more specialties and services;
   - development of an extrapolation method for visits;
   - revision, refinement, and expansion of the measurement of pre- and post-work;

- **expansion and validation of the extrapolation methodology;**
- **development of expanded relative value estimates for services for which global fees are customarily utilized as standard definitions are developed and accepted;**
- **appropriate action to address concerns specific to individual specialties; and**
- **that the AMA work to establish a mechanism to ensure that additional concerns that may be identified are communicated to and addressed by the appropriate parties and external validation is conducted by the AMA.**

BALANCE BILLING

Currently physicians may choose whether or not to accept Medicare assignment on each claim. They may also choose whether or not to become "participating physicians," meaning that they agree to accept Medicare assignment on all Medicare claims for a one-year period. Physicians submit assigned claims directly to Medicare carriers and bill patients only for the coinsurance amount; they must accept the Medicare allowed amount as payment in full and not "balance bill" patients. A major policy use of assignment is to reduce the financial liability of beneficiaries. Assignment acceptance and balance billing policy have been controversial topics in the current Medicare payment system. Policy on this issue will be a critical feature in the design of a new Medicare physician payment system based on an RBRVS.

The AMA has long opposed mandatory assignment and supported physicians' right to establish their own fees. In addition, the AMA has had a number of serious concerns about the Medicare Participating Physicians Program and has sought repeal of it and the MAAC limits established in the current system. Although the Association was not successful in obtaining a court finding invalidating MAACs, the October 14, 1988 written opinion of the United States Court of Appeals, Fifth District, recognized the MAACs as being "ridiculously" complex, and as deterring top students from applying to medical school.

The AMA supports voluntary assignment programs established by state, county, or national medical specialty societies aimed at acceptance of assignment for low-income individuals. Currently 11 such programs are in place. The Association also urges physicians to consider their patients' ability to pay and to accept assignment or charge a reduced fee or no fee in instances of patient financial need.

A new payment system is likely to introduce uncertainties about rates of assignment acceptance and potential beneficiary financial liability. Under the current payment system, Medicare allowed charges as a percent of submitted charges have steadily declined to a current average reduction of 27%. Despite this large discount, the rate of assignment acceptance has increased to the point that, in the first quarter of 1988, 76% of Medicare claims were accepted on assignment. For the remaining 24% of claims, physicians may bill patients for the balance of their fee (subject to MAAC limits).

The average balance bill is equivalent to 20% of the allowed charge. In 1985, prior to implementation of MAACs, 92% of Medicare beneficiaries paid less than $500 in balance bills, and only 2% paid more than $1,000. The average amount of balance billing in 1985 per nonparticipating physician was $7,500.

Under strong pressure from advocates for the elderly, Congress and the PPRC will want to "protect" Medicare beneficiaries from financial liability arising from balance bills, in part or in full, in the design of a new payment system. In its 1988 report to Congress, the PPRC made no recommendations on balance billing policy, but noted that choosing between assignment acceptance policy options would entail tradeoffs between limiting beneficiary financial liability and preserving patient access to their physician of choice. The 1989 PPRC report will likely contain detailed recommendations.

Mandatory assignment legislation has been enacted in four states since 1985: Massachusetts, Vermont, Rhode Island, and Connecticut. The Massachusetts provision is the only state statute that makes acceptance of the Medicare allowed amount as payment in full a condition of licensure. In the other three states, assignment is mandatory for elderly patients meeting income eligibility criteria. Connecticut was one of 16 states that considered mandatory assignment legislation this year; bills in 12 states were defeated. In four states - New Jersey, New York, Ohio, and Pennsylvania - bills are still pending. Bills are expected to be introduced or reintroduced in many states in 1989, including Arkansas and Texas.

Balance Billing and Medicare Expenditures

Policy makers will need to consider the potential effects of mandatory assignment on Medicare program expenditures under a new payment system. The RAND Health Insurance Experiment examined utilization behavior and expenditures by the non-elderly population under four different coinsurance rates. The presence of coinsurance produced a substantial decrease in the number of visits, with the largest decrease occurring between the group who paid no coinsurance and the group paying 25% coinsurance.

Medicare requires Part B beneficiaries to pay a deductible and 20% copayment for the services they receive. In 1986, 71% of beneficiaries purchased private supplemental insurance policies, "Medigap," to cover deductibles and coinsurance, and 9% had their deductibles and coinsurance covered by Medicaid. The remaining 20% of the Medicare population are the only beneficiaries who actually pay their coinsurance out-of-pocket. For the 71% of beneficiaries who have Medigap, a percentage of claims are accepted on assignment. For those who have Medigap and whose claims are unassigned, balance bills, which average 20% of the Medicare allowed amount, may act as de facto coinsurance in constraining utilization of services.

A 1987 study by the Congressional Budget Office (CBO) suggests that the RAND findings can be applied to the elderly population. The CBO found that Medigap coverage increased use of physician and hospital services by 24%. The study concluded, "The prevalence of Medigap insurance . . . eliminates the constraints on unnecessary use intended to result from Medicare's cost-sharing provisions. As a result, use of Medicare-covered services is higher than it would otherwise be, and most of the costs of the additional services used are paid by Medicare rather than by Medigap insurers."*

Recent evidence further suggests that high assignment rates may entail a tradeoff between beneficiary financial protection and increasing Medicare program costs. An analysis of assigned versus unassigned charges from 1984 through 1987 found that unassigned charges declined somewhat and then stabilized so that, by 1987, approved charges on assigned claims accounted for virtually all of the increase in total Medicare expenditures. Research on the impact of cost-sharing on utilization suggests that a probable explanation is that reduced balance billing led to increased patient demand for care.

These analyses of the relationship between Medicare expenditure growth and increasing assignment rates indicate that current policies aimed at encouraging assignment acceptance and limiting balance billing may be having an adverse effect on the federal budget. A new Medicare physician payment system that eliminated balance billing could have a substantial upward effect on beneficiary utilization and concomitant increases in Medicare expenditures.

Balance Billing and Market Performance

Physician services are not uniform, and can be expected to vary from the average services upon which a Medicare RVS and payment schedule are based. Services with the same Medicare payment will vary according to practice costs, quality of care and experience of the physician, and the average severity of illness of the patients in a physician's practice. In addition, the demand for and supply of the different services provided by physicians will vary from community to community.

By allowing physicians to set their fees commensurate with the actual services they provide to their particular group of patients and with local market conditions, balance billing will compensate for the imprecision of the RBRVS-based schedule of Medicare allowances. ***It is impossible to develop a fee schedule that could account for all of these factors and hence appropriately price all Medicare physician services in a manner that would adequately and***

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*Christensen, S, Long, S, and Rodgers, J, "Acute Health Care Costs for the Aged Medicare Population," Milbank Quarterly 65 (3), 1987, p. 409.

precisely compensate physicians for their work and assure beneficiary access to their physician of choice. As James S. Todd, MD, AMA senior deputy executive vice president, stated in his JAMA editorial on the RBRVS study:

> *No one should consider an RBRVS, which itself has no monetary meaning, as fulfilling the criteria necessary for a fixed fee schedule. The RBRVS, like any RVS, is based on averages. . . An RBRVS-based system cannot recognize differences between physicians in patient mix, quality, or practice costs. Nor can it account for local market conditions that affect access to care. . . A properly working RBRVS-based fee schedule will require the flexibility that comes with the ability to balance bill. . . Rigid price regulations inevitably produce distortions that harm consumers and producers alike.*
>
> (260:16, p. 2440-41, 1988)

Price Consciousness

Under a simplified fee schedule system, indemnity principles will increase the price consciousness of both patients and physicians. Medicare's payment for a service would be readily known to both parties. The degree of additional patient liability, if any, would be apparent through a comparison of this amount and the physicians' usual charge. Such a system will:

- increase Medicare patients' demand for price information;
- facilitate physicians' provision of fee information;
- increase the frequency of substantive fee negotiations between physicians and patients; and
- increase the level of price competition in physician services provided to Medicare beneficiaries.

Recommendation

Retention of the ability to balance bill under a new Medicare physician payment system remains a major AMA policy objective. Hence, the Board recommends: 4. That the Association reaffirm its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing; 5. That the AMA reaffirm its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits; 6. That the Association promote enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system; 7. That the Association expand its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

TRANSITION

Moving from the CPR method of paying for physician services in the Medicare program to an RBRVS-based payment system will represent a significant change in Medicare reimbursement policy and a redistribution of relative Medicare payments among specialties. Discussion of a transition period focuses on how to implement the new payment system without causing disruption in the delivery of physician services to Medicare beneficiaries.

Board of Trustees Report OO (A-88) recommended that the AMA support a reasonable transition period to a new system, but did not make a recommendation on a specific transition period. The AMA has also stated support for phasing in any new Medicare physician payment system in testimony before the PPRC. The two basic issues related to a transition from the CPR system to an RBRVS-based physician payment system are the method for determining payments during the transition and the length of time of the transition period. The 1988 PPRC report did not comment on either of these issues. The March 1989 report will make detailed recommendations.

A transition period reduces the change in any given year. For physicians whose relative portion of Medicare dollars would decrease under a new fee schedule, income will be earned during transition that would not have been received under a full, immediate implementation. In addition, a transition period enables the change to a new payment system to be sufficiently integrated with other changes occurring in medical practice to minimize the impact on any particular group of physicians or beneficiaries.

During a transition period it is possible that, due to overall payment updates, actual payments to some physicians would increase even though their relative payments were being decreased. An immediate change, on the other hand, would simultaneously decrease actual and relative payments, and hence lead to needless disruption.

Finally, a transition period provides an opportunity to monitor the effects of and make needed revisions to a new payment system prior to its full implementation. In considering the method of transition, the Board analyzed the following possible alternatives:

- a blending transition, similar to that under the Medicare Prospective Pricing System (PPS), in which physician payments would be determined in increasing proportion by an RBRVS-based indemnity payment schedule and in decreasing proportion by CPR (or prevailing charges only);

- a continuation of the CPR system with a combination of higher-than-MEI updates for visits and freezes (or selected cuts) on non-visits until CPR allowed charges resemble RBRVS/fee schedule payments; and

- immediate implementation of an RBRVS-based system, with limits on annual percentage losses and gains for specialties, individual physicians, or specific services.

Although the latter two alternatives could potentially minimize disruption, implementation of either model could be extremely complex. For example, under the "freeze non-visits, increase visits" approach, each service would essentially have its own transition period. Because the RBRVS would change the relative values of procedures one to another, in addition to revaluing visits relative to non-visits, it would be difficult to calculate appropriate payment levels each year. Overall, such a process would take approximately 13 years to roughly realign visits and procedures according to RBRVS patterns. For many procedures, the transition period under this option could exceed 20 years.

The "limit losses and gains" alternative would also be difficult to administer. Decisions would need to be made about whether loss and gain limits applied to individual services, specialties, or individual physicians. Limits applied to services or specialties could still allow individual practices to exceed loss and gain limits, but the calculations entailed in a physician-specific approach could be prohibitively complex.

There are several arguments supporting use of a blending approach in the transition to a new physician payment system. Because the blending approach was employed in the PPS, the concept is familiar and there is some administrative experience with it. It would also be a simpler system to implement than the other two transition alternatives, since the same basic formula would apply to payments for all physician services.

A blending transition is still complex, however. It will be critical that sufficient carrier resources are committed to accurately calculate and inform physicians of Medicare allowed amounts. Use of prevailing charges only, rather than also maintaining customary charge profiles, might simplify administration of a blending transition. Before the AMA can adopt a more detailed policy on a specific transition period, more analysis will be required.

Recommendation

The Board recommends: 8. That a Medicare indemnity payment system be implemented through a blending transition, in which physician payments would be determined in increasing proportion by an RBRVS-based indemnity payment schedule and in decreasing proportion by the current CPR payment system, or prevailing charges only. The specific transition period should be chosen in order to strike an appropriate balance between minimizing disruptions for patients and physicians while also minimizing the complexity of the process. In addition, the effects of the new system should be monitored during the transition, with corrections made as needed.

GEOGRAPHIC PAYMENT VARIATIONS

A critical policy issue in the design of a Medicare physician fee schedule is adjusting payments to reflect geographic differences in practice costs. If physician payments are geographically adjusted, the AMA will need policy regarding a cost-of-practice index to identify appropriate geographic multipliers, and how Medicare payment localities should be determined. Inclusion of beneficiary access as an additional locality adjustment is also a consideration.

Resolutions 88 and 127 (A-88) called for a single national Medicare fee schedule with no geographic variation due to practice costs. In contrast, current AMA policy supports geographic differences in Medicare physician payments under an indemnity payment system that reflect differences in the costs of practice. Under a uniform national fee schedule, _actual_ payments to physicians would be equal across geographic areas, whereas under a fee schedule that is adjusted for geographic differences in _practice costs_, the intent is to make the _net payment_ to physicians equal across geographic areas.

Under the CPR method of determining physician payments, the nation is divided into approximately 240 different charge localities. In each locality, the Medicare carrier determines prevailing rates, theoretically on the basis of historical charge patterns. This policy, combined with the constraining effects of the MEI and the lack of uniformity in determining locality boundaries, has created substantial variation in prevailing charges among the 240 localities that is apparently unrelated to variations in practice costs.

The final report of the Harvard RBRVS study indicated that if the RBRVS is used as a basis for a fee schedule, geographic variation in costs among physicians should be reflected in the conversion factor. Similarly, the PPRC recommends that as part of a fee schedule, geographic multipliers should determine how payments will differ among areas. According to the PPRC, unless Medicare payments are computed in accordance with practice cost variations, physicians may be discouraged from practicing in areas with high costs.

The geographic payment variation issue is still under study by HHS and the PPRC. Most parties agree, however, that any new Medicare physician payment policy aimed at reducing current geographic payment differentials will need to recognize that some variation due to justifiable differences in physician practice costs is warranted and necessary. Simulations based on a preliminary geographic cost index suggest that a Medicare physician payment policy designed to promote a uniform Medicare payment for a particular service, and hence a single national fee schedule, would tend to _heighten_ rather than moderate the redistributional effects of a Medicare RBRVS fee schedule.

Cost-of-Practice Index

Development of a fee schedule that is adjusted for geographic variations in practice costs requires a cost-of-practice index. In OBRA 1986, Congress mandated that HHS develop such an index. An interim index has been developed by Zuckerman et. al. at the Urban Institute, with funding from HCFA, which encompasses the prices of overhead items (e.g., office space, non-physician salaries, professional liability insurance -- approximately 45% of the index) and the physician's net income (the remaining 55%). HCFA plans to complete its final index by March 1989.

Measuring the variation in physicians' overhead costs is both logical and feasible. Measurement and inclusion in a geographic payment index of variations in physician input is more difficult and controversial, with many arguing that the physician input component should be held constant. If physician input were to be included in a geographic payment index, there are several ways that it could be measured. Use of a cost-of-living index is one alternative, although opponents argue that physicians living in high cost communities may receive amenities such as climate and recreational opportunities that provide adequate compensation for these high costs. An alternative approach would use variations in earnings data to reflect the combined effects of cost-of-living, amenities, and physician location preferences. On balance, for reasons of equity and simplicity, the Board of Trustees is of the opinion that only the approximately 45% of an indemnity payment schedule conversion factor that is based on overhead costs should vary geographically, and hence, believes that current AMA policy should be retained.

Determination of Payment Localities

Under CPR, the method of determining the 240 charge locality boundaries is inconsistent. Medicare carriers independently determine their own boundaries and, as a result, current charge localities are delineated by state, by metropolitan/nonmetropolitan area, and even by congressional district. The PPRC favors the development of a uniform policy to set locality boundaries for use in a fee schedule. According to the PPRC, "localities should be homogeneous with respect to costs of practice, should avoid sharp differences in geographic multipliers between adjacent localities, and [should] be administrable." Current charge localities do not meet these criteria.

Alternatives to the current charge localities are the use of the nine census regions, the use of states, or the use of substate localities such as metropolitan and nonmetropolitan areas. Medicare's PPS has set a precedent by using the nine regions in the transition to national DRG payment rates. In its April 1986 report, the CBO indicated that adjusting physician payment rates by state would be appropriate because taxes, licensing and insurance regulations, and legal systems already vary by state. As a further adjustment, the CBO believes that setting separate payment rates for metropolitan and nonmetropolitan areas within each state may be desirable.

There is a tradeoff between reflecting smaller area variations in physician costs and building an index that uses data on actual physician costs rather than proxies. Current surveys of actual physician overhead, including the AMA's Socioeconomic Monitoring Survey (SMS) and the HCFA-sponsored Physician Practice Cost and Income Survey (PPCIS) provide statistically reliable data at the state level for only a very few states. Thus, research on cost of practice indices at the state or substate level relies heavily on data that only provide an estimate of actual physician costs. The major exception is for professional liability insurance, for which substate data are available from several sources. The cost of the current PPCIS is approximately $1.5 to $2 million. Collecting data at the substate level would increase the costs three to four-fold.

These data considerations and tradeoffs suggest that national uniformity in the determination of payment localities may not be desirable. Given the benefits of simplicity and the need to reflect cost variation as accurately as possible, the available data might best support a combination of regional, state, and substate localities. Such a policy would hold geographic variation in payment rates to the level that can be supported by high quality data on practice costs.

Access Adjustment

Aside from the development of geographic multipliers and payment localities, there may be additional non-practice cost factors that would necessitate a payment adjustment. These factors, such as changes in physician population or local market conditions, may be an indication that appropriate beneficiary access to care has been adversely affected. Thus, concern over beneficiary access may justify the inclusion of an access adjustment to the geographic multipliers under a fee schedule. Such an adjustment factor could be applied to areas with demonstrable access problems. A method of measuring access across geographic areas should be developed to support implementation of such an access adjustment and implemented as feasible.

Recommendation

The Board recommends: 9. That the AMA reaffirm its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs; 10. That payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan/nonmetropolitan areas within states) based on the availability of high quality data; 11. That geographic differentials should be addressed simultaneously with specialty differentials; and 12. That, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

SPECIALTY DIFFERENTIALS

The issue of whether or not physicians in different specialties should receive different payments for services that are assigned the same CPT code is an important question in the design of an RBRVS fee schedule for Medicare. This topic encompasses three separate issues: first, whether or not specialty differentials are appropriate, and, if so, on what basis; second, if specialty differentials are paid, for what services; and, third, if such differential payments are appropriate, how should a "specialist" be defined.

A specialty differential is a difference in the amount paid to different specialists for services designated by the same procedure code. Current AMA policy supports the methodology used in the CPR system to recognize specialty differentials, which traditionally has reflected differences in charging patterns among specialties. Development of a new physician payment system for Medicare based on the resource costs of providing physician services requires that this policy be reconsidered.

The PPRC stated in its March 1988 report to Congress that "any change in policy for specialty differentials before implementation of a new fee schedule would impose substantial administrative costs on carriers and physicians, and its effects on access, cost, and quality would be difficult to predict." Although the PPRC is not ready to recommend a specific policy, it believes that specialty differentials would be unnecessary for most procedures performed by physicians due to the precision of the coding system for these services. The commission further believes that differentials should only exist "if the content and work for a service differ among specialists."

Under the current Medicare system, there is no uniform policy for setting prevailing charges by specialty. Medicare carriers are allowed to establish different prevailing charge limits for different specialties. Most Medicare carriers have some specialty fee screens, although five of 39 surveyed by HCFA in 1985 made no distinctions among specialties. Fourteen of the surveyed carriers grouped specialties, and 17 had individual prevailing charge screens for each specialty (as defined by the carriers).

Of 11 carriers surveyed by the General Accounting Office (GAO) in 1984, six use more than 20 prevailing rates and five used from one to three rates. Although the number of prevailing charge screens is supposed to be determined by physicians' charge patterns, five of the six who used more than 20 rates based their rate structure on a listing of medical specialties and had not performed any supporting analyses.

Specialty differentials under an RBRVS-based fee schedule have an entirely different basis and impact than under the CPR system. In an RBRVS, services may be defined as "same" or "different" based either on the level of work involved in providing the service, the practice or training costs associated with the service, or the clinical content of the service. The magnitude of the difference in resource costs is also a consideration in determining the appropriateness of different payments.

Distinctions between generalists and specialists and among different specialists present the two major dimensions of the specialty differential issue. Many services and procedures are specialty specific and are provided almost exclusively by particular specialists. In such cases, a specialty differential would seem to be unnecessary or irrelevant. The issue of the appropriateness of paying a differential is not so clear for services generally provided by more than one type of specialist.

The most complex issue with regard to specialty differentials concerns the visit, which is provided by almost all physicians. Total work, the major component of the RBRVS, was first measured on a specialty specific basis. Even after services were placed on a common scale, the Harvard RBRVS reports specialty differences in total work for visits and consultations with the same code. In addition, as part of its basis in resource costs, the Harvard RBRVS maintains specialty differentials for all services based on the opportunity costs of advanced training and on practice costs. **Thus, the Harvard RBRVS contains different relative values for the same CPT code for services provided by more than one specialty.**

The same reasoning that supports variations in fee schedule payments across geographic areas based on differing resource costs supports basing differential payments to specialties on identified variations in resource costs. Informed policy decisions on specific differentials, however, will depend on how Harvard, the PPRC, HCFA, and the AMA Ad Hoc Committee on Visits and Levels of Service deal with final relative values, extrapolation, and coding for evaluation and management services. Much will also depend on the final treatment of practice costs. In particular, the PPRC wants to replace Harvard's specialty-specific treatment of practice costs with an approach that will focus on the individual service, thus eliminating one potential source of specialty differentials.

As the Board's evaluation of the Harvard study indicated, the precision and coding of Harvard's relative values for visits and consultations and the inadequacy of their method of measuring relative practice costs are two areas requiring considerable attention and technical refinement. The currently reported differences in specialty work for visits and the differences based on practice costs do not yet provide a solid basis for determining either (a) whether there are differences in the work of different specialists providing services assigned the same code, (b) whether current visit codes are appropriate as the basis for a fee schedule, or (c) the exact magnitudes of specialty differentials based on work or practice costs. Policy on specific specialty differentials must be based on sound data as it becomes available rather than on philosophy.

Identification of Specialty Services

A second specialty differential issue is the distinction between services that specialists provide that are within their specialty and general or primary care services that are not specific to their specialty, but for which differential payments are established in a fee schedule. When specialists practice within their specialties, there is little controversy on this issue. For example, an internist will not be practicing orthopaedic surgery.

When a subspecialist practices within the broader specialty for which he or she is also trained, however, there may be questions about which specialty differential should apply if an RBRVS value exists for both the specialty and the subspecialty. For example, when a rheumatologist provides primary care to a patient, if there are separate specialty differentials for general internists and rheumatologists, should the rheumatologist be paid as a general internist or a rheumatologist? Similarly, if general surgeons or obstetricians provide primary care, how should they be paid?

Payment of the specialist or subspecialist rate for all services provided by a physician may be perceived by some as inequitable. On the other hand, implementation of payment policies that would pay specialty differentials only for identified specialty or subspecialty services would introduce a considerable amount of administrative complexity into the new payment system through use of new modifiers, diagnosis codes, or other cumbersome additions to the claims process.

Definition of a Specialist

Since its inception, the Medicare program has allowed carriers to recognize self-designation, board certification, "board eligibility," or any combination of these definitions of "specialist" within the Medicare payment system. As reported in the PPRC's March 1988 report, this policy has resulted in 24 carriers allowing self-designation, three requiring board certification, and five accepting board certification or equivalent training.

The PPRC favors a nationally uniform method of designating physicians as specialists. The AMA currently has no policy on the identification of a physician as a specialist except insofar as the Physician Masterfile so designates. For the Masterfile, practice specialties may be self-designated by the physicians, data on board certification are collected from the American Board of Medical Specialties, and data on residency training come from a survey of accredited residency training programs.

The Association did, however, recently comment on what criteria should be used to define "specialist," in response to HCFA's April 12, 1988 request for comments on the discontinuation of specialty differentials. In its comments, the AMA stated that "a variety of criteria are valid. The existence or lack of board certification should not be a sole determinant for ascertaining whether someone qualifies as a specialist. The bottom line is the competence of the individual physician to provide the services normally associated with a specialty practice and the make-up of the physician practice."

Although self-designation as a specialist has been the historical method of identifying specialists for practice and payment purposes, its continued use may be questioned by some policymakers. For example, in its March 1988 report to Congress, the PPRC rejected the possibility of self-designation as a means of identifying specialists under Medicare, stating that the criteria for identifying specialists "must be easy to apply and validate and should reliably indicate the specialized skill and judgment expected of a specialist."

At the other end of the continuum, a rigid definition of specialist, such as board certification, appears to the Board inconsistent with criteria for payment differentials that are based on actual resource costs or clinical content. Although peer recognition (e.g., hospital privileges) would be more difficult to administer than board certification or level of training conditions (e.g., completion of residency training), this policy would be fairer to those physicians who are capable of practicing a specialty despite not completing certification requirements. Medicare carriers could also identify physicians practicing as specialists -- for example, the new radiology RVS will apply to physicians for whom 50% of their billings come from radiological procedures as identified by CPT code.

The Board agrees with the PPRC that national criteria for identifying specialists should be developed, but also believes that discretion should be left to carriers to adapt these criteria to local needs. This flexibility could be especially important in areas where specialists are now in short supply. Illustrative national criteria could involve completion of residency training or specific years of residency training plus time in practice as a specialist. Other administrative guidelines will also be needed, such as the availability of a hearing or administrative process, so that a county medical society or a hospital medical staff could attest to the specialty practice of a particular physician if the carrier had questions about the specialty qualifications.

Whatever criteria are used in a fee schedule, a provision must be included under which physicians who have practiced as specialists for a number of years would be given the opportunity to become board certified or to meet any of the agreed upon criteria within a specified period of time. For example, this process would allow older physicians, who as a group are less likely to be board certified, to continue their present practices until retirement or to meet the new criteria. Such a provision, with its own "sunset" clause probably would be widely acceptable.

Recommendation

The Board recommends:

13. That the AMA support the general principle that an RBRVS-based payment schedule should include differentials in payment for CPT codes where there are differential resource costs ("total work" and practice and training costs) across specialties. The following criteria should guide the establishment of differentials for specific services:

a. When the resource costs are substantially different across specialties; and

b. When the relevant codes are not sufficiently precise to differentiate among the content or physician work of a service across specialties, and cannot be readily refined to become so.

In addition, as few separate payment categories as possible should be established to minimize system complexity. In general, specialty differentials should be avoided except where absolutely warranted by resource cost data.

14. Specialty differentials should apply to all CPT-coded services for which a differential exists.

15. Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to:

- **Partial completion of a residency plus time in practice;**
- **Local peer recognition; and**
- **Carrier analysis of practice patterns.**

A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

OTHER IMPLEMENTATION ISSUES

Initial Conversion Factor

Multiplication of the final RBRVS by a monetary conversion factor is the process by which an initial fee schedule will be created. Since the conversion factor will have a major effect on the overall level of Medicare payments for physician services, it provides a mechanism for using the RBRVS to simultaneously achieve budgetary and access goals.

The PPRC has stated that the principal determinant of the conversion factor will be its implications for the federal budget and beneficiary Part B premiums. The commission also recognizes that the conversion factor will affect beneficiary financial liability and access. Two conversion factor options were outlined in the 1988 PPRC report: the first is selection of a "budget neutral" conversion factor; the second entails setting a desired budget for Medicare physician services independently of projected expenditures under CPR and determining the conversion factor that would be likely to achieve this result.

A "budget neutral" conversion factor would neither increase nor decrease Medicare expenditures compared to what they would have been expected to be in the coming year under CPR. For example, if the year 1991 was the first year of implementation of a fee schedule, and expenditures for physician services were forecasted to increase by 12% from 1990 to 1991, a budget neutral conversion factor would be based on a budget projection that was 12% higher than 1990 expenditures. Also, this method of forecasting expenditures allows for expected increases in volume, but itself establishes neither an expenditure cap nor a floor. In other words, actual expenditures may either exceed or fall short of the forecasted amount.

There is a strong indication of congressional interest in using the initial conversion factor to achieve significant budget savings. When the legislation establishing a radiology RVS as the basis for Medicare payments to radiologists was passed, it provided for 3% savings from budget neutrality. Using a conversion factor aimed at achieving budget savings, payments for visits could still be slightly increased, but decreases in payments for non-visits could bring severe losses for some physicians. Payment cuts of this magnitude could also cause access to be threatened.

Medicare allowed charges currently average 27% below physicians' submitted charges. A conversion factor that increased this discount could make it difficult for some physicians to continue to provide services to their elderly patients. The Medicare discount from private sector payments is one measure of Medicare patients' access to physician services relative to private sector patients.

Recommendation

The Board recommends: 16. That the Association strongly oppose any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

Updating the Fee Schedule

A new Medicare physician payment system will require timely updates in the monetary conversion factor and in the RBRVS. The process for updating the conversion factor will require analyses of trends in practice costs, general inflation, professional liability insurance premiums, the cost of new technology, and other relevant costs. Updating the RBRVS will also require analyses of changes in medical practice and technology.

In selecting update processes, policy makers will have a variety of models from which to choose, each with differing implications for physicians, beneficiaries, and the federal budget. Available models offer varying forms and levels of involvement for Congress, HCFA, the PPRC or newly formed commissions, beneficiaries, and organized medicine. The update processes that are selected should:

- maintain the adequacy of Medicare benefits through ensuring access to care and protection against undue financial burdens on beneficiaries;

- reflect a prudent concern with federal budgetary realities;

- be administratively, financially, and legally feasible;

- provide for reasonable levels of compensation for physicians who treat Medicare patients;

- allow a meaningful opportunity for physician participation; and

- use the most current data on beneficiary access, practice costs, other economic developments, and clinical practice.

Active participation in the update processes would offer the profession an unprecedented role in determining policy on economic and social issues that will have a major impact on medicine. A strong consensus among physicians will be critical to achieving updates that are in the best interests of the profession and its Medicare patients. If Medicine is fragmented, all physicians will lose.

Recommendation

The Board recommends: 17. That whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience, and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

Volume and Intensity

The volume and intensity of Medicare physician services continue to be major factors in overall expenditure increases for these services. Many policymakers fear that a new Medicare fee schedule based on an RBRVS will not provide adequate budget savings. In addition, they are concerned that payment changes associated with an RBRVS-based fee schedule might induce physicians to generate services or to "upcode" to offset payment cuts.

The most frequently mentioned means of directly controlling or offsetting increases in volume and intensity of services are expenditure targets or regional budget caps. Expenditure targets would adjust the annual update in the unit payment (conversion factor) for physician services in a geographic area based on how Medicare expenditures in that area compared to a target. A budget cap would resemble an expenditure target but would more directly limit expenditures in a region by capitating an entity that would be responsible for care in that area. In effect, a very large HMO would be created. Although there was interest in regional capitation a few years ago, current attention seems to be focusing on expenditure targets, which tend to place risk on providers rather than a capitated organization.

The PPRC seems extremely interested in using expenditure targets to accompany a new RVS/fee schedule. There is also strong congressional interest in this approach. Targets would be set for per capita expenditures in an area adjusted for the age, sex, and other risk factors of the population as well as Medicare's current expenditures in an area. If the target is exceeded in one year, the fee schedule conversion factor for that area might be reduced in the next year.

The PPRC has identified a number of complex design issues, including:

- Whether to adjust all Medicare payments or only physician payments;
- Whether to base targets on the rate of increase in expenditures, the previous level of expenditures, or both;
- Whether to adjust payment updates or payment levels;
- Whether to base targets on all Medicare expenditures or only physician expenditures;
- How to balance budget constraints, technological and other medical advances, and practice guidelines in setting targets;
- Which geographic unit to use (e.g., counties, metropolitan areas, states, the entire nation); and
- Whether to fine tune all regions or only to change payments for areas that have especially large positive or negative variances from targets.

The PPRC envisions that targets might be administered by an organization of physicians (e.g., a state medical association), a Medicare Peer Review Organization, or a Medicare carrier. They recognize that their major problem is meshing physician incentives with targets to avoid triggering cuts. In one sense, they want to use information and practice guidelines to help physicians stay within the targets. In another sense, they are asking physicians to accept much of the insurance risk for Medicare that the federal government currently accepts.

The Association is strongly opposed to expenditure targets. The sources of growth and change in Medicare expenditures and services are poorly understood. Appropriateness studies are in their infancy. Medicare data on geographic expenditure levels are not timely and are subject to wide and unexplained annual variations. Growth in service volume is also uneven across specialties and types of service. Expenditure targets would therefore penalize all physicians, even those who may be contributing relatively less to expenditure growth. In addition, beneficiary access would likely be eroded in areas that exceeded targets.

Physicians do not need expenditure targets in order to address the utilization and appropriateness of care. The AMA is working to develop constructive approaches to effective utilization review, and will be working with the RAND Corporation in the development of scientifically-based "practice parameters." Similarly, physicians, individually and through their various professional organizations, continue to expend considerable energy and resources on professional education and enhanced quality and appropriateness of care.

Recommendation

The Board recommends: 18. That the Association strongly oppose implementation of Medicare expenditure targets, which will lead to the rationing of care for Medicare beneficiaries, and instead support constructive approaches to enhancing quality and appropriateness of care.

IV. CONCLUSIONS AND RECOMMENDATIONS

Continuing high rates of growth in Medicare expenditures for physician services, and mounting pressure to reduce the federal budget, have made Medicare physician payment reform a focal point on Congress' agenda. Congressional and Administration attention to physician payment has to date produced fee freezes, MAACs, inherent reasonableness cuts, and proposals for widespread capitation, DRGs, Medicare PPOs, and expenditure caps. With the implementation of MAACs and inherent reasonableness cuts, the CPR system became moribund. The alternatives to CPR offered to date pose serious threats to the ability of physicians to continue providing high quality, accessible health care for their Medicare patients.

Medicine must have its own Medicare payment proposal. An RBRVS-based indemnity payment system has been viewed as a credible alternative and has already served the profession well in restraining some of the enthusiasm for more disruptive proposals.

The Board of Trustees has carefully evaluated the Harvard RBRVS submitted to the Health Care Financing Administration. The Board has also considered whether and how this RBRVS could be used as the basis for a new Medicare indemnity payment system. In particular, the Board has addressed several of the key policy issues that must be resolved if an RBRVS is to be used in such a system. This will not be the final Board of Trustees report on the RBRVS. The Board will continue to expend all necessary efforts to ensure both the successful expansion and refinement of the Harvard RBRVS and the appropriate use of these data by the PPRC and HCFA. The Board will, of course, report on the results of its efforts in a timely fashion. More refined and detailed AMA policy on the issues considered in this report will only be possible with more definitive RBRVS recommendations from Harvard, HCFA and the PPRC.

Thus, policy decisions on the RBRVS and related issues will be critically dependent on the final Medicare RBRVS, on what the PPRC will recommend to Congress in April, and on the course set by President-elect Bush and the Congress. In order for the profession to influence the ultimate outcome, the position of Medicine must be clearly understood by all. Accordingly, at this time, the Board recommends that the following policies be adopted:

1. That the AMA reaffirm its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using:

    a. an appropriate RVS based on the resource costs of providing physician services;
    b. an appropriate monetary conversion factor; and
    c. an appropriate set of conversion factor multipliers.

2. That the AMA adopt the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare indemnity payment system.

3. That the AMA work with Harvard, the national medical specialty societies, the PPRC, HCFA, other interested and knowledgeable parties, and the Congress to refine and modify the Harvard RBRVS to ensure that it is technically adequate and can be implemented in a timely and minimally disruptive manner when needed revisions have been satisfactorily completed. Refinement and completion of the RBRVS will require:

    - appropriate restudy of the services of specialties whose RBRVS data have significant, documented technical deficiencies;
    - fundamental improvement of the measurement of practice costs and amortized specialty training costs;
    - expansion of the RBRVS to more specialties and services;
    - development of an extrapolation method for visits;
    - revision, refinement, and expansion of the measurement of pre- and post-work;
    - expansion and validation of the extrapolation methodology;
    - development of expanded relative value estimates for services for which global fees are customarily utilized as standard definitions are developed and accepted;
    - appropriate action to address concerns specific to individual specialties; and
    - that the AMA work to establish a mechanism to ensure that additional concerns that may be identified are communicated to and addressed by the appropriate parties and external validation is conducted by the AMA.

4. That the Association reaffirm its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing.

5. That the AMA reaffirm its oppostion to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

6. That the Association promote enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

7. That the Association expand its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

8. That a Medicare indemnity payment system be implemented through a blending transition, in which physician payments would be determined in increasing proportion by an RBRVS-based indemnity payment schedule and in decreasing proportion by the current CPR payment system, or prevailing charges only. The specific transition period should be chosen in order to strike an appropriate balance between minimizing disruptions for patients and physicians while also minimizing the complexity of the process. In addition, the effects of the new system should be monitored during the transition, with corrections made as needed.

9. That the AMA reaffirm its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

10. That payment localities should be determined based on principles of reasonableness, flexibility, and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan/nonmetropolitan areas within states) based on the availability of high quality data.

11. That geographic differentials should be addressed simultaneously with specialty differentials.

12. That, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

13. That the AMA support the general principle that an RBRVS-based payment schedule should include differentials in payment for CPT codes where there are differential resource costs ("total work" and practice and training costs) across specialties. The following criteria should guide the establishment of differentials for specific services:

    a. When the resource costs are substantially different across specialties; and

    b. When the relevant codes are not sufficiently precise to differentiate among the content or physician work of a service across specialties, and cannot be readily refined to become so.

    In addition, as few separate payment categories as possible should be established to minimize system complexity. In general, specialty differentials should be avoided except where absolutely warranted by resource cost data.

14. Specialty differentials should apply to all CPT-coded services for which a differential exists.

15. Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to:

    - Partial completion of a residency plus time in practice;
    - Local peer recognition; and
    - Carrier analysis of practice patterns.

    A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

16. That the Association strongly oppose any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

17. That whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience, and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

18. That the Association strongly oppose implementation of Medicare expenditure targets, which will lead to the rationing of care for Medicare beneficiaries, and instead support constructive approaches to enhancing quality and appropriateness of care.

19. That this report be adopted in lieu of Resolutions 88 and 127 (A-88).

TECHNICAL APPENDIX

AMA EVALUATION OF THE RBRVS STUDY

EVALUATION CRITERIA

Board of Trustees Report OO (A-88) identified eight specific evaluation criteria for assessing the Harvard RBRVS study:

- Sample selection focuses on the size and representativeness of the samples of physicians surveyed by the Harvard investigators. Sample sizes must be large enough to produce statistically valid results. Representativeness concerns whether the sampled physicians are sufficiently representative of all physicians in their specialty.

- Selection of services and procedures to be surveyed within and across specialties is important for assessing the probability that the work on which the RBRVS is based accurately reflects what physicians in the surveyed specialties do.

- Analysis of the survey instrument includes evaluation of its validity and reliability. Reliability refers to whether the survey results are consistent and reproducible. Validity refers to how well the survey findings agree (1) with physicians' beliefs and assessments about their work, and (2) with what an independent observer or other measuring techniques would verify.

- Assessment of Harvard's use of the TCGs focuses on the effectiveness of this process for incorporating medical expertise into the study.

- Examination of the researchers' use of secondary data sources is especially relevant to the practice and training cost components of the study.

- Evaluation of the Harvard model and statistical methods explores the basic approach to developing the RBRVS and the appropriateness of the statistical methods used.

- Analysis of the cross-specialty linkage process includes the appropriateness of the linking services and the mathematical models used to combine the specialty-specific RBRVSs into a common scale.

- Assessment of the extrapolation methodology addresses assumptions and data entailed in extrapolating relative values from the surveyed procedures to related non-surveyed procedures.

Evaluation of each of the components of Harvard's research methodology according to these criteria, as appropriate, permits an overall assessment of the study's strengths and weaknesses. This assessment in turn suggests the answer to the question of whether the study succeeded in achieving its goals and objectives. The major features of each component of the RBRVS study are summarized below and assessed according to applicable evaluation criteria.

Measurement of Intra-service Work

a. Pilot Survey

Harvard's methods for gathering physicians' ratings of total work, time, and the four components of intensity were new to this study. Hence, the Harvard investigators conducted a pilot survey to assess the validity of their method in measuring work. To pilot test the national survey, a survey instrument was developed and tested in telephone interviews with physicians in four specialties: general surgery, internal medicine, anesthesiology, and radiology.

The random sample selected for the pilot survey was drawn from the 1986 AMA Physician Masterfile, and was limited to 500 nonfederal, patient care physicians in the New England Census Division. In addition, physicians were excluded from the sample if they worked in patient care less than 20 hours per week, were in residency training, were over 65 years of age, or had no current address in the AMA Masterfile. Prior to the telephone interview, sampled physicians were screened to ensure that they met sample criteria and were sent: letters from Harvard and the AMA requesting cooperation; a description of the magnitude estimation method; a list of the survey procedures; and a description of the dimensions on which they would be asked to rate the procedures. The pilot survey achieved an overall response rate of 73.1%.

The study team conducted several types of statistical analyses in order to assess the validity and reliability of the survey instrument and method. In order to simplify this statistical analysis, each physician's rating for a particular service was transformed by taking its logarithm to the base 10. Ratings considered as extreme outliers were dropped and treated as "missing." Ratings from physicians for whom the combination of actual missing responses and outlier responses led to more than 45% of their ratings being categorized as missing were also dropped (16 out of 266 respondents). The initial analysis of responses yielded geometric means (approximate median values) indicating the work entailed in each surveyed procedure relative to the standard for the specialty, which was set at 100.

According to the Harvard report, the TCG physicians who reviewed the ratings produced by the pilot survey generally found them reasonable. Reports from AMA staff attending the TCG meetings concur with this assessment. This contrast with the two previous attempts to measure physician work suggested to the researchers that magnitude estimation was a valid method of measuring work.

A second analysis addressed the reliability of the ratings, meaning that it assessed the extent to which a survey of a different sample of physicians could be expected to produce the same ratings as the pilot sample. The statistical method used in this reliability test found that the pilot sample's ratings were highly reliable.

Finally, a third analysis explored the validity of Harvard's definition of the components of work by assessing how well the surveyed physicians' ratings of the individual dimensions of work predicted their ratings of total intra-service work for each service. The findings from this analysis suggested that physicians' ratings of the components of work were good predictors of their ratings of total intra-service work. This analysis suggested that the survey instrument measured what it was intended to measure, and hence that the measure of work could be used in a national survey.

b. National Survey

The national survey of intra-service work employed essentially the same instruments and methods as the pilot survey, but sampled a larger number of physicians in each of 18 specialties. Also, combining physical effort and technical skill into one dimension and hence reducing the dimensions of work from five to four made it possible to increase the number of procedures surveyed from 17 to approximately 22 in each specialty.

Estimates of sample size requirements were based on response rates and standard deviations of the data from the pilot survey, and resulted in a random sample from the AMA Physician Masterfile of 3,164 physicians, with from 165 to 183 in each specialty. In addition to the exclusions outlined above, the national sample excluded Doctors of Osteopathy, graduates of foreign medical schools who were temporarily licensed in the U.S., and physicians who were included in the pilot survey. The method used to determine sample size requirements was appropriate.

A total of 1,977 interviews were completed, for a response rate of 62.5%; 60% would have been considered acceptable by the investigators. Although this response rate may be adequate, it does leave greater room to question the representativeness of the sample than would, for example, an 85% response rate. In particular, to investigate whether the ratings of non-respondents may have differed in any systematic way from those of respondents, it is necessary to identify sub-samples of physicians whose ratings might be expected to approximate those of non-respondents. The sample size may not be adequate, however, to permit statistically valid comparisons between some of these sub-samples.*

Statistical analysis of the findings from the national survey confirmed the reliability and validity estimates of the pilot test. In addition, the representativeness of the sample was extensively assessed, and it was found to be generally representative according to geographic region and board certification. The investigators also compared characteristics of the responding physicians, including board certification, years since medical school graduation, practice characteristics, and geographic region, with those of non-respondents. This analysis suggested that it was unlikely that the ratings of those physicians in the sample who did not respond to the survey would have been systematically different from the respondents' ratings. Nevertheless, the response rate does not permit a definitive conclusion that the ratings of non-respondents would not have differed in any systematic way from those of the respondents. Still, the available evidence strongly suggests that the sample responses were representative.

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*For example, the investigators suggest that the ratings of those physicians who required more telephone calls to obtain a response may approximate the ratings of non-respondents. A preliminary analysis determined that the number of telephone calls was not generally related to physicians' rating of work. A more thorough analysis of non-respondents, however, might compare ratings of those respondents for whom 30 or more calls were needed to those of the larger sample. The report does not indicate how many respondents would be in that category, however, and whether a valid comparison with the larger sample would be possible.

An additional test of the reliability of the survey results compared ratings for the 52 services that were included in both the pilot and the national survey. The comparison found statistically significant differences in the results from the two different samples in only three out of the 52 cases. In general, the results from the two surveys were within 10% of each other, with the greatest differences for evaluation and management services. To further assess the validity of the survey results, reported times for eight surgical procedures were compared with operating room times from eight hospitals and were found to be similar.

The report of the survey concluded with suggestions for additional analysis of the survey results to better address potential concerns about both the validity and the representativeness of the sample:

- as noted above, detailed assessment of the relationship between the number of calls needed to obtain a response and physicians' ratings, to assess whether the responses of physicians who were harder to reach differed in any systematic way from those who responded after fewer calls, and hence whether non-respondents' ratings would likely have been different;
- comparison of the relationship between the ratings of fee-for-service versus salaried physicians to determine if ratings of work may have been influenced by physicians' charge patterns; and
- analysis of the relationship, if any, between the frequency that respondent physicians performed a service and their ratings of work.

To summarize, ***evaluation of the survey of intra-service work suggests that this component of the RBRVS study was well designed and that the investigators used appropriate statistical tests to assess the reliability and validity of their results.*** The *CCG's* assessment found that this component of the study was successful in measuring physicians' intra-service work, and that appropriate statistical tests were used with "generally excellent" results. The *CCG* also performed a separate test to determine if Harvard's results for representative specialties simply mirrored existing charge structures, and found that this was not the case.

The weakest portion of the study, as reported, is the lack of external validity checks, meaning comparison of the survey results with other measures of resource costs. In this regard, the comments of the TCG physicians, who provided the strongest check on the how well the survey results reflected clinical practice, do not receive sufficient attention in the study's final report. More detailed discussion of the TCG's reactions to the survey findings might provide more evidence on the validity of this measure of intra-service work.

In addition, it is clear that the study would have benefited from more timely provision of information to TCG physicians, as well as a greater responsiveness to some of their expressed concerns. AMA staff will work to ensure that use of the TCGs during the second phase of the study is improved to respond to these deficiencies.

Cross-Specialty Analysis

The national survey of intra-service work produced RBRVSs for each of the specialties included in the study, with each specialty's surveyed services ranked by intra-service work relative to that specialty's standard service. The purpose of the cross-specialty analysis component of the study was to place all of the surveyed services for the 18 specialties on a common scale of intra-service work. The Cross Specialty Panel met three times during this process.

As part of the process of selecting services for the national survey, TCG panelists were asked to identify services performed in their specialties that were also performed in other specialties. In addition, services were identified by the investigators as "potentially the same" that were performed by more than one specialty but had not been initially described by the TCG panelists as the same service. After discussion with physicians in the Cross Specialty Panel, services were considered "the same" if: (1) the vignettes describing them were identical; (2) the intra-service time required to deliver the service was the same; (3) the process of diagnosis and treatment was the same; and (4) the average patient seen by the different specialties was roughly of the same complexity. To provide additional links between the specialties, a second category of "equivalent" services was identified, consisting of services that were different and were performed by different specialties but required an equal amount of time and involved the same level of intensity.

Following the national survey, the intra-service times obtained from the survey were compared with the cross-specialty panelists' judgments. Services whose times differed by more than 25% were dropped as cross-specialty links. Also, by clustering services from the national survey that had similar intra-service times and work and presenting these clustered services to the cross-specialty panel, additional equivalent service links were identified.

To align the specialty-specific RBRVSs, the ratings of the linking services for each pair of RBRVSs were used to statistically align the scales such that the final locations of the linking services on the common scale were as close as possible. A reproduction of Figure 3 from the final report (attached) illustrates this alignment process for two specialties. The alignment results in the intra-service work values for different standard services being defined relative to one another and in the linking services being as close as possible on the final scale.

All of the 133 links were aligned using this statistical process, so that all surveyed services were located on a common cross-specialty scale of intra-service work. The alignment process generally worked well. There were imperfections, however, because the different specialties' judgments of work were not exactly the same. The sampling errors were also small, confirming that the sample size in the national survey was adequate for this component of the study.

To evaluate the linkage process, the investigators addressed two questions: (1) could the TCGs have selected linking services that were unusually similar so that successful alignment was a mere coincidence, and (2) were some links better than others and should they therefore have been weighted higher than others to improve the alignment? Statistical analysis demonstrated that neither of these concerns was valid.

The investigators suggest several sources of potential error or bias in the alignment process that might be explored through additional analysis:

- if all the linking services selected by the cross-specialty panel for one specialty required less work than the services at the other end of the links, the standard for the specialty would be assigned an improperly high value;
- the alignment process relied on median rather than mean judgments -- use of means might have resulted in a different common scale of work; and
- use of alternative but more complicated statistical procedures may have resulted in a different common scale.

Overall, the study's approach to linking the specialty-specific RBRVSs on a common scale appears to be methodologically sound and to have produced valid results. This view is supported by statistical tests performed by the investigators, as well as by the *CCG's* analysis. In addition, all of the linking services were required to pass the scrutiny of either the TCGs, the cross-specialty panel, the survey respondents, or a combination of the three groups, which provides a strong indication that they were, in general, appropriately selected. Of course, it would be useful to conduct the three additional analyses suggested by the investigators (above) to further evaluate this methodology. It would also have been highly desirable to have had considerably more in-depth TCG review of final cross-linked relative values. In addition, a few specialties were weakly linked and require further study.

Pre- and Post-Service Time and Work

Total work was defined by the Harvard researchers as encompassing the time and intensity involved in the actual delivery of a service (the intra-service portion discussed above), and the time and intensity of physicians' efforts prior to and following service delivery, termed pre- and post-work. For in-hospital surgical procedures, pre- and post-work included physician services provided from the time of the patients' admission until hospital discharge, and hence excluded preadmission or post-discharge care. To measure pre- and post-work, surveyed services were divided into six categories (evaluation and management, invasive, imaging, laboratory, pathology, and anesthesia) and five service settings (office, hospital, surgical center, emergency unit, and nursing home).

Data on pre- and post-times for a subset of services (153) were obtained from two surveys. The first was the national survey of intra-service work, in which physicians in the 18 specialties were asked to estimate pre- and post-times for three of the 22 surveyed services. The second was a survey of 560 physicians in seven specialties (66% response rate), who were asked to estimate the pre-, intra-, and post-times for

121 services. These data were then used in a regression analysis to estimate pre- and post-times for the remaining services.

Since the type of work involved in the period prior to and following a service was thought to consist essentially of evaluation and management activities, pre- and post-work was derived using a combination of pre- and post-time information and data from the national survey on the work involved in evaluation and management services. Pre- and post-work was hence defined as the product of _time_ and _work per unit of time_. In addition, procedures with relatively high ratings for intra-service work were assumed to also have similarly relatively high ratings for pre- and post-service work. Finally, services defined in the cross-specialty analysis as "same" services were assumed to have the same pre- and post-work. Through a statistical process of clustering services within their categories and service settings and according to their intra-service work values, _work per unit of time_ values were assigned to the pre- and post-times for each service.

Pre- and post-service time estimates were reviewed by the TCGs and times for office visits were compared with data from other studies and adjusted accordingly. To assess whether the responses of those physicians who did not respond to the second survey would have biased the survey results, the time estimates of those physicians who responded to the first survey but did not respond to the second survey were compared with those of physicians who responded to both surveys. This analysis suggested that such bias was unlikely. Other statistical analyses addressed the likely accuracy of the statistical method that assigned time to non-surveyed services and the reliability of the times.

Estimates of work per unit of time were reviewed by clinicians on the study team. In the few cases in which the clinicians' assignments differed significantly from the statistical prediction, a simple average of the clinicians' values and statistical assignments was used. To further assess reliability, work per unit of time estimates from the national survey for services that comprised a portion of another surveyed service (i.e., post-operative hospital visit) were compared with work per unit of time estimates from the statistical method. This comparison found similar results from both methods.

Review of this component suggests that additional work is needed to refine and validate the methods used. The *CCG* reports that, although the study made sophisticated use of limited data, these data are less reliable than the results for intra-service work. Reported pre- and post-times from the study's two surveys differed substantially, and sample sizes for some specialties in the second survey were small. Also, analysis of the statistical method used to estimate pre- and post-work indicates that there could be significant errors in these data.

The investigators admit to imprecision in the estimates of pre- and post-work as a result of combining survey data, predicted estimates, and secondary data; however, they suggest that the _relative_ nature of an RVS would minimize the impact of unsystematic biases, and that moderate inaccuracies in pre- and post-work would not have a large impact on total work. Nevertheless, because pre- and post-work accounted for a substantial percentage of total work, ranging between 30% and 50% for most of the studied services, it is essential that better data on this component of work be collected and that the methods used to estimate pre- and post-work be validated and refined.

Extrapolation to Nonsurveyed Services

The basic RBRVS study developed total work ratings for 372 distinct services provided by the 18 specialties (including 35 cross-specialty services with "same" total work values). To extrapolate from the surveyed services to additional CPT-coded services provided by these specialties, Harvard relied on a charge-based extrapolation within clusters of closely related CPT codes defined as "families." Essentially the same methodology was proposed in the AMA's 1985 proposal to develop an RBRVS. Families begin with a surveyed procedure and are extended by CPT code to include those codes that are:

- performed by the same specialty (except the 35 "same" services);
- performed in the same setting;
- within the same general category (i.e., invasive);
- involve the same body system;
- involve the same anatomic part; and
- entail the same type of procedure (i.e., incision, repair).

Within each family, the Harvard investigators used Medicare and Health Insurance Association of America (HIAA) national frequency-weighted average charge data to determine the ratio of charges for other services in the family to the charge for the surveyed procedure. The relative value for the surveyed procedure was then multiplied by the ratio for each of the other procedures to obtain relative values for the families. The approximately 2,000 codes in the resulting RBRVS accounted for about 80% of Medicare charges for 17 of the studied specialties, (excluding anesthesiology) compared with 40% of charges accounted for by the surveyed procedures.

Harvard initially adopted this system based on its theory regarding the distortions that insurance coverage and other factors have created in relative charge data. Harvard argued that charge distortions would be substantially minimized within closely related groups of services that were provided by the same specialty, had similar insurance coverage, and had been introduced at roughly the same time.

Harvard provided initial charge data to the TCGs at their first meetings for review as a possible basis for extrapolation. The reactions of these physicians were generally positive.

In their final report, Harvard provided an initial statistical assessment of their assumption that within closely related groups of services, relative charges closely approximated relative resource costs. They estimated the percent of the variation in work explained by charges for their surveyed services. Charges alone explain 86% of the variation in work. There were, however, major systematic differences in the unexplained variation for broad categories of services (i.e., visits, imaging, invasive).

This finding suggested that grouping services into smaller and more closely related groups of services would improve the ability of charges to predict work values. A second analysis incorporating groupings that resembled very broad "families" increased the level of variation explained to 93%. Harvard concluded that the narrower family groupings used in the actual extrapolation process would provide an even closer relationship between charges and work.

After completing its extrapolations in the summer of 1988, Harvard quickly created a new review committee composed of both TCG physicians and physicians unfamiliar with the study to review these results. Because of the difficulties of using small groups of reviewers to pass judgment on market-generated data representing the experience of many physicians, Harvard deliberately adopted a strict criterion for identifying "unreasonable" estimates, based on their decision to either accept or reject a relative value, but not to attempt to use the review panel to modify extrapolated values. Fewer than 15% of the extrapolated services were found to be clear outliers.

Sources of unreasonable charge-based extrapolated values included:

- Rank order anomalies in the charge data (e.g., 6 vessel CABG lower than 3 or 4 vessel CABG);
- Overly compressed charge data (e.g., charges for limited office visits for new patients were almost the same as for intermediate visits - such charge compressions for visits led Harvard to reject this method of extrapolation for these services);
- Services not provided by physicians (e.g., pathology services provided by technicians);
- Services with specific costs for supplies or equipment;
- Services billed in an "unconventional manner" (e.g., allergy tests);
- Services that included a global service; and
- Obsolete CPT codes.

It is clear that many of these problems are not related to charge data per se, but rather to specific specialty circumstances and billing practices. Many of the rank order and compression problems probably result from the use of national volume-weighted average charge data, especially for services that are infrequently performed.

The Harvard investigators concluded that the charge-based extrapolation methodology could not be applied to evaluation and management services. In particular, they found rank order anomalies in charge data and that charges were more compressed than resource costs. They attributed the problems with extrapolation for these services to ambiguity in the CPT code descriptions, variations in coding and billing practices between specialties, and limitations in the charge database. In addition, the investigators did not use the charge-based extrapolation methodology for anesthesiology services, and instead proposed using an RVS based on time and complexity developed by the American Society of Anesthesiologists for that purpose.

The basic concept of using charge ratios within related categories of services to extend the RBRVS to non-surveyed services is the best method available for achieving this purpose. Nevertheless, evaluation of this component of the study raises a number of concerns:

- Although the investigators attribute problems in extrapolating to evaluation and management services to variations in coding practices between specialties, only limited evidence is presented to support this view. Since surveyed physicians were not asked how they would code the vignettes and often were not provided enough information in the vignettes to easily permit definitive assignment of a CPT code, the study did not obtain any information on these alleged variations. Conversely, this problem appears to arise from the investigators' decision to select descriptive vignettes and then map the vignettes to CPT codes, rather than to choose coded services for which relative values were desired and then select vignettes that would be representative of these CPT-coded services.

- The use of national frequency-weighted average Medicare charges can lead to anomalies and/or compression in RBRVs that probably would not occur in individual charge localities.

- By selecting vignettes for the survey of intra-service work prior to identifying the CPT families for which relative values were required, a number of families did not contain any surveyed services while others contained more than one. One result of this approach is that the RBRVS represents the range of services provided by some specialties better than others.

The investigators need to refine their development and use of vignettes for evaluation and management services. They also must explore other data available for extrapolation, and may need to survey additional evaluation and management services. Also, the AMA Ad Hoc Committee on Visits and Levels of Service is working with HCFA, the PPRC, and Harvard to explore refinements in CPT codes for these services to make them better suited to measuring differences in work while remaining clinically meaningful.

Finally, a more systematic review process by broader groups of physicians within the affected specialties will be needed to evaluate extrapolated values. In particular, there must be a mechanism to not only identify potentially erroneous distortions but to revise relative values in a credible manner. The AMA has a clear leadership role to play in this process.

Relative Practice Cost Differences Among Physician Specialties

According to AMA data, practice costs (those costs of practice other than the physicians' time and effort) account for nearly 50% of physicians' average gross revenue. The study focused on developing an index of relative specialty practice costs based on the average percentage of each specialty's gross income that was accounted for by these costs.

Although actual costs of practice vary from service to service according to the inputs required, there are limitations on the availability of cost data on a service-by-service basis, and the accounting literature suggested to the investigators that physicians generally allocate their overhead costs across all the services they provide. For these reasons, in developing the index, practice costs were assumed to be allocated over all specialty services according to the physician work involved in the service. In addition, the study did not address geographic variations in practice costs, stating that such variations were best addressed in the implementation of an RBRVS-based payment system.

Two sources of data were available for developing the index, the AMA's Socioeconomic Monitoring System survey (SMS) and the Physician Practice Cost and Income Survey (PPCIS). Because it covered more of the specialties included in the study, the PPCIS, based on a survey of 2,525 physicians, was used to develop the index. The survey provided information on expenditures for office space, equipment, supplies, nonphysician wages, nonphysician fringe benefits, and professional liability insurance premiums. The relative practice cost factor for most specialties fell within a 15% range, with the specialties of pathology and psychiatry having lower practice cost ratios than most and the specialties of orthopaedic surgery and rheumatology having higher ratios.

The final report of the study identifies several problems with the methodology and the data used in calculating practice costs, including:

- the PPCIS data were from 1983;
- the sample sizes for some of the specialties were extremely small;
- the ratios of practice costs to income are based on income under the current payment system, so that the change to an RBRVS-based fee schedule would likely alter the appropriate ratios; and
- the method of allocating costs across all specialty services does not distinguish between services provided in office settings and in non-office settings.

The *CCG's* review states that these problems increase the probability of "significant inaccuracies". In particular, the use of practice cost ratios based on current specialty incomes introduces significant distortions. For example, if the distributional effects of an RBRVS-based fee schedule were such that revenues for a specialty would be cut and a practice cost ratio based on income prior to the revenue cut was used, the specialty's revenue loss could be seriously exaggerated.

To address these problems, the authors suggested potential alternative approaches to practice cost adjustments to the RBRVS, including separating practice costs from the RBRVS and incorporating them into the monetary conversion factor. Each of the problems outlined in the report severely limits the validity and usefulness of the final specialty practice cost factors.

As part of its evaluation of the Harvard study, the *CCG* developed practice cost factors using data from the AMA SMS rather than the PPCIS. A comparison with the PPCIS-derived ratios shows that the SMS reports higher expense percentages (10%) for family practice and psychiatry, and lower expense percentages for general surgery (-6%), anesthesiology (-5%), and orthopaedic surgery (-7%). An analysis by the AMA Center for

Health Policy Research reached similar conclusions, highlighting the sensitivity of Harvard's practice cost formula to the particular cost data used. The PPRC's work on the practice cost component of an RBRVS is likely to focus on the ratio of specialty practice costs to total work rather than income, to treat professional liability insurance separately from other costs, and to attempt to allocate practice costs across the services provided by each specialty in a more accurate manner.

Measurement of the Amortized Opportunity Costs of Specialty Training

The third factor in the RBRVS equation, amortized costs of specialty training, is based on the length of postgraduate medical education required by each specialty. The opportunity costs of specialty training were defined in the study as the difference between a resident's salary and the income the resident could earn in general practice. These opportunity costs were summed for each specialty and amortized over the working lifetime of the physician, and calculated as a percentage of net income. Using data from the AMA and a survey conducted by Medical Economics, an index of specialty training costs was developed. This component of the study had a relatively small effect on total work. Using general surgery as the standard, the training cost factor for internal medicine was 1% less than general surgery and for thoracic surgery was 5% more than general surgery.

A weakness that this component of the study shares with the practice cost component is its reliance on current specialty income levels. In one sense, the effect of maintaining these current relative incomes is greater in the opportunity cost component, however, because it is based on lifetime earnings. On the other hand, since the amortized costs of specialty training represent a much smaller proportion of physicians' annual incomes than the 50% accounted for by practice costs, the net effect of basing this factor on current incomes is small.

Study Results

Major findings from the study include:

- The intensity of physicians' services varies widely across services. Work per minute ranges from a low of 1.4 to a high of 19.4, with average work per minute for evaluation and management services less than half that of invasive services. There is more variation in work per minute for invasive procedures than for other types of services.

- Physicians' work prior to and following the actual provision of a service (pre- and post-work) comprises a substantial portion of total work, from an average of 33% for evaluation and management services to 50% for invasive services.

- Although estimated resource cost values for invasive procedures are strongly correlated with submitted charges for these services, the wide range in ratios of Medicare charges to relative values for invasive procedures, from 0.42 to 2.32, suggests that relative Medicare charges do not accurately reflect relative resource costs for these individual services.

- The RBRVS suggests that visits should be valued more closely to invasive services than they are by relative Medicare charges. The study demonstrated that the relationship between visits and non-visits was derived from within-specialty survey results rather than the cross-specialty linking process. Because of the inability to extrapolate for evaluation and management services, however, it is difficult to define the exact visit values with precision.

The investigators cite a number of limitations of the study in their final report:

- The RBRVS does not take into account differences in patient severity, quality of care, benefits of care, or patient demand.

- The study methodology could not reliably extrapolate relative values for non-surveyed evaluation and management services.

- The RBRVS does not provide values for surgical services billed globally, defined as those for which post-operative office visits are included with the operation in one charge. The RBRVS can be used, however, to build global relative values given specific global "packages."

- The study only incorporated inter-specialty differences in practice costs, but did not account for differences in practice costs between services provided by the same specialty.

To address some of these limitations, the investigators recommended that additional research be conducted to expand the RBRVS to include non-surveyed specialties and all of the most frequently performed Medicare services, to develop a better extrapolation method for evaluation and management services, and to complete the RBRVSs for psychiatry and anesthesiology, which are described as tentative.

Conclusions of Evaluation

Evaluation of the Harvard RBRVS final report reveals that the study has a number of strengths, but also some serious weaknesses. The conclusions of the *CCG's* assessment of the study are as follows:

> *The RBRVS study's major effort -- the measurement of physicians' "intra-service" work (i.e., the work needed to perform specific services and procedures) -- was successful. The RBRVS researchers designed and conducted pilot and national surveys of physicians about this work and its components. They obtained generally accurate, reliable and consistent rankings of relative work from each of 18 specialties for about 22 representative services. These separate specialty-specific rankings were also successfully linked into a common scale. These results show that it is feasible to develop a work scale built on physicians' views about their work. Such a scale represents the foundation for a complete RBRVS scale.*
>
> *As the RBRVS study moved beyond national survey-based work estimates to assess other resource costs, the researchers had to use less reliable data and rely more upon complex estimating techniques and*

> *extrapolation methods. Key difficulties proved to be inadequacies in the federal government's data on physicians' practice costs, work measurement and data for extrapolation of the CPT-4 visit codes, verification of extrapolation methods, and limited data on pre- and post-service work effort.*

The primary data used to develop the RBRVS were the results of the surveys of physicians' work and the cross-specialty alignment process; and these components are also the strongest from a methodological perspective. The investigators have given considerable attention to the size and representativeness of their samples. The data that have been produced on the work involved in physician services have passed appropriate statistical tests of reliability and validity as well as the scrutiny of practicing physicians. The method that has been developed for assessing work has been demonstrated to obtain reproducible results and to accurately measure total work and its components. The basic relationships between services that were identified in the specialty-specific surveys, such as the ratings for visits relative to non-visits, were maintained and confirmed by the cross-linking process.

The extrapolation methodology may also be regarded as a strength of the study, although it is not as well validated. For the majority of services within the families of codes surveyed by Harvard, physician reviewers found that the charge-based extrapolation method produced relative values that approximated relative resource costs.

There are three major weaknesses in the study methodology: the treatment of relative specialty practice costs, the inability to extrapolate for non-surveyed evaluation and management services, and the lack of validation of the pre- and post- work estimates. In addition, as the study report suggests, additional work is required to develop relative values for a greater number of services in some specialties, and there needs to be more attention given to global billing and completion of the RBRVS for anesthesiology and psychiatry.

A more systematic review process by broader groups of physicians within the affected specialties will be needed to evaluate extrapolated values. In particular, there must be a mechanism to not only identify potentially erroneous distortions but to revise relative values in a credible manner. The AMA has a clear leadership role to play in this process.

In addressing the question of whether the study accomplished its goals, the answer is affirmative for some goals and negative for others. The study did succeed in developing a methodology for measuring the relative work involved in physician services, but, because of the problems with the practice cost factor, did not adequately measure all of the resource costs of physician services. The relative values of work can therefore be accepted as generally valid, but not the overall RBRVS. In addition, because of the limited number of surveyed evaluation and management services and the incomplete scales for psychiatry and anesthesiology, the study remains to some degree incomplete.

The weaknesses and limitations outlined in the study's final report and in this evaluation can all be categorized as areas in need of further attention. They do not represent intractable problems. Additional study can produce a more appropriate measure of relative specialty practice costs, a more refined method of measuring pre- and post-work, and a more comprehensive RBRVS. With sufficient resources, this work could permit timely completion and implementation of an RBRVS based on the Harvard data.

The Harvard study has to date succeeded in developing a valid methodology for measuring relative physician work and has produced an initial scale of resource-based relative values for most of the services provided by 18 specialties. **The Board of Trustees remains committed to the development of a complete, refined RBRVS for physician services.** Refinement and completion of the RBRVS will require:

- Improvement of the Measurement of Practice Costs

  The PPRC has taken the lead in this area and has already made considerable progress toward addressing the major concerns raised in this evaluation, including use of high quality data and ratios of costs to total work rather than current income. The AMA will furnish its data and expertise to aid this effort.

- Expansion of the RBRVS to More Specialties and Services

  A more comprehensive RBRVS is the major goal of the second phase of the Harvard study, which is already underway. This second phase will expand the study to 15 additional specialties, survey additional services for general and orthopaedic surgery and for internal medicine, and, if necessary, survey additional evaluation and management services provided by specialties surveyed in the first phase.

- Development of an Extrapolation Method for Visits

  Since problems in this area stem from several factors, including the wording of vignettes, their relationship to CPT codes, and distortions in use of national charge data, they must be addressed on several fronts. The AMA Ad Hoc Committee on Visits and Levels of Service is working with HCFA, the PPRC, and Harvard to address problems in the use of current CPT visit codes for defining physician work in the RBRVS study. In the second phase of the study, Harvard will need to provide more information relevant to physician work and coding in its descriptive vignettes and explore alternative extrapolation methods.

- Refinement of the Measurement of Pre- and Post-Work

  The second phase of the Harvard study offers an opportunity to validate the reliability of the method used in Harvard's second survey of pre- and post-time, and to develop and validate a more logical approach to assigning work per unit of time values. Presumably, the complex, multi-layered approach used in the first phase was a result of unanticipated findings regarding pre- and post-work. These findings should assist in refining methods in the second phase.

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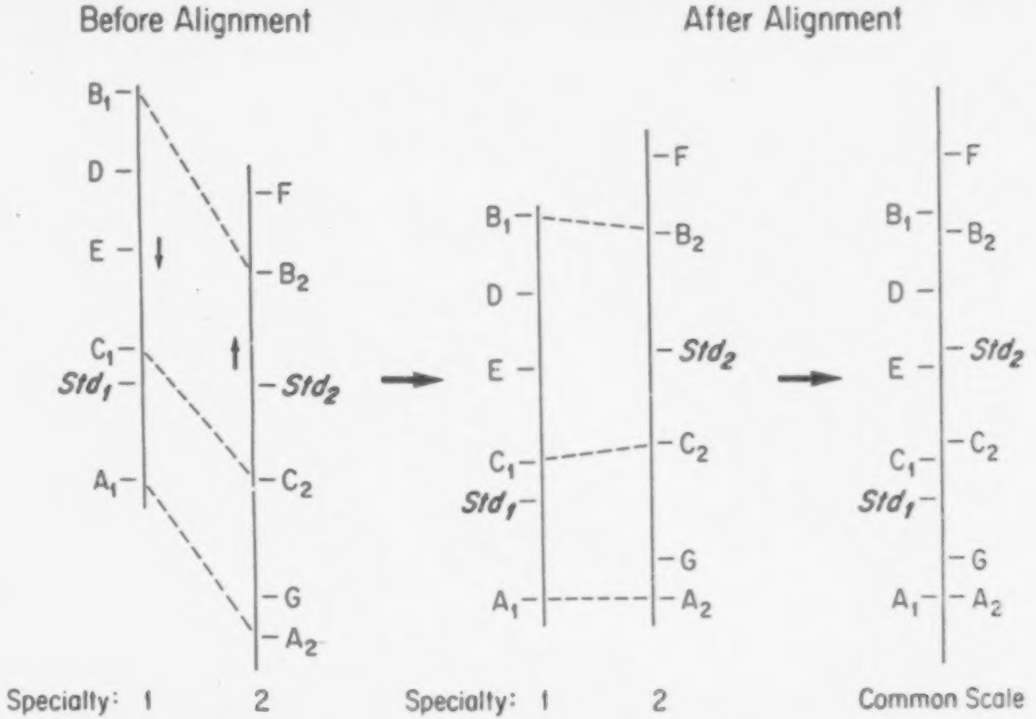
- Expansion and Validation of the Extrapolation Methodology

  The process of selecting vignettes/codes to be surveyed in the first phase of the study provided insufficient data to validate the charge-based extrapolation method. Obtaining such data should be an explicit objective in the second phase. The AMA will play a leadership role in ensuring more systematic review by broader groups of physicians to evaluate extrapolated values. In addition, a method should be developed to expand the RBRVS to those families of CPT codes that do not contain a surveyed service.

- Continuation of Evaluation and External Validation

  The AMA and members of the Federation will continue to evaluate the final report of Harvard's first phase and may identify additional technical concerns. The AMA evaluation has focused on general issues regarding the technical adequacy and validity of the Harvard RBRVS. In addition, several specialties have identified problems and questions relating to their particular experience. The AMA will work to help these specialties resolve these difficulties. In particular, AMA evaluation activities will focus on verifying that the complete and expanded RBRVS, to be forthcoming pending completion of the preceeding steps by Harvard, the FPRC, and HCFA, accurately reflects all components of the relative resource costs of physician services, both as physicians perceive them and as objective measures demonstrate. The AMA will work to establish a process that ensures that (1) additional concerns that may be identified are communicated to and addressed by the appropriate parties, and that (2) external validation is conducted.

Figure 3. A qualitative view of the cross-specialty alignment process: specialty and common scales for work


Before Alignment
After Alignment
B₁
D
E
C₁
Std₁
A₁
F
B₂
Std₂
C₂
G
A₂
Specialty: 1
2
Specialty: 1
2
Common Scale

The link services (A, B, and C) serve to align individual logarithmic scales of work onto a common scale by a least squares method. Reference standard services (Std), used to establish the individual specialty scales, shift relative to one another. The relationships of services within the specialty scales and the ranges are unchanged.

Chairman **Sasser**. We will now hear from Ms. Burgess, on behalf of the American Association of Retired Persons.

STATEMENT OF LOVOLA BURGESS, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY STEPHANIE A. KENNAN, AARP LEGISLATIVE REPRESENTATIVE, HEALTH FEDERAL APPLICATIONS

Ms. **Burgess**. Mr. Chairman, I am very pleased to be here and representing the American Association of Retired Persons. My written statement will outline several areas of concern about our administration's budget proposals, but I am going to zero in on the medicare budget proposals.

First of all, to begin with, we recognize that medicare will once again be subject to budget cuts. The question we have is the extent and the nature of the cuts. In medicare part A, which pays for hospital care, as you know, the solvency of the HI Trust Fund is much improved. We should remember that it was only a few years ago that it was projected to be insolvent by 1987. It is now projected to be solvent until past the turn of the century, but part A will require continued close oversight to assure that it remains solvent.

Part A has borne the greater portion of recent medicare budget cuts. Moreover, medicare's prospective payment system has helped contain costs, while still providing access to care. AARP believes that medicare should not assure providers a certain return on investment, rather, it is our policy that medicare rates should be sufficient on-average to compensate providers fairly.

Number two, the association does not support the severity of the administration's budget proposals. We do believe, however, that if there is room for improvement, gradual reductions in payments under part A. While the administration's proposal for reductions to indirect medical education are too severe, threatening the viability of institutions which provide the highest levels of care to the sickest patients, a gradual reduction may be possible.

Similarly, continuation of the 15 percent reduction in capital payments may well be warranted, but increasing the rate of reduction to 25 percent, as proposed by the administration, could prevent needed rehabilitation of the deteriorating physical plants of our large city hospitals—and we have discussed that somewhat before.

AARP supports ProPAC's recommendations with respect to the annual update for the hospital market basket. We are concerned about hospitals which serve disproportionately high numbers of medicare patients. Although some hospitals should close, we are concerned about closures which cut off access to care for less mobile persons. AARP urges Congress to consider ProPAC's recommendations which take into account different costs in rural, large urban and other urban areas.

Three, now I would like to turn part B of medicare, which pays for physician care. Despite efforts to control costs, part B continues to be one of the fastest growing domestic programs, straining both the Federal budget and the pocketbooks of beneficiaries.

The growth of the program is attributable to both increase in prices and volume of services delivered. Beneficiaries have strong reasons to support further actions to control spending in part B.

Despite cost containment efforts, beneficiary out-of-pocket costs continue to rise rapidly. Annual part B premiums have increased 91 percent since 1984. Coinsurance has increased from $2.1 billion to over $7 billion in 1988.

The administration's budget will reduce payments to physicians by $2 billion and raise an additional $600 million by continuing the requirement that part B premiums equal 25 percent of program costs. A cut of this magnitude would be, we believe, excessive.

Four, the association does not support the continuation of the requirement that part B premium equal 25 percent of program costs. While beneficiaries want to pay their fair share of medicare costs, they cannot be expected to continue to pay 25 percent of the cost of a program over which they have no control.

Some claim that the increases in volume under medicare are caused by beneficiary demand for services. Mr. Chairman, I would like to state very clearly that the doctor, not the patient, is the decisionmaker concerning tests and procedures.

Five, the administration's budget calls for reducing certain overpriced procedures. AARP has supported similar reductions in the past and would be prepared again to do that, to support an approach which would reduce overpriced services, while investing some of the savings in undervalued services such as primary care.

We would point out, however, that when such investment occurs, beneficiaries' coinsurance amount actually goes up for these services, increasing costs again to the patients.

Number six, we know from past history, however, that when price increases are limited, our reimbursement to health care providers is reduced. Patients must be protected from cost shifting. Congress has acted to do so in the past, through limits on balance billing. We strongly urge continuation of this kind of restraint, otherwise provider cuts are simply passed on to beneficiaries.

And number seven, ultimately, however, we need long-term cost containment of part B. The association has long supported a resource-based relative value scale as a means for achieving fair and rational fees for physician payment. It is important to understand, however, what the impact will be on the individual beneficiary.

While part B reform may be deficit neutral in the aggregate, I do not visit my doctor in the aggregate. I have specific medical needs. Thus, some beneficiaries may see costs go up, even as others see their costs go down.

And number eight, the association supports the development of practice guidelines as a means of determining the effectiveness of certain procedures versus others in specific situations. Thus, we should be able to determine better what quality of care should be. The medical community will need to be involved in the organization and implementation of the guidelines.

If organized medicine does not participate fully, we are likely to have to move toward more intrusive steps that may be uncomfortable for both the doctor and the patient.

Another proposal to reduce costs, particularly volume of service, that has been discussed lately is expenditure targets. That was mentioned briefly before. AARP approaches this issue quite cautiously. For example, we are concerned about such issues as to what happens to the other purchasers of health care if expenditure targets in medicare were to be put into place.

In short, Mr. Chairman, to address the long-term problem of the budget deficit, we must also address long-term reforms of part B. We urge you to make decisions concerning part B which will be consistent with efforts to reform part B over time. We look forward to working with you on that challenge.

I do thank you and I will be pleased to take any questions that you may have.

Thank you.

Chairman SASSER. Thank you, Ms. Burgess.

[The prepared statement of Ms. Burgess follows:]

AARP

STATEMENT

OF THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

BEFORE THE

BUDGET COMMITTEE
OF THE
UNITED STATES SENATE

ON

MEDICARE

MARCH 8, 1989

PRESENTED BY:

Lovola Burgess
Vice President
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of Retired Persons

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Louise D. Crooks *President* Horace B. Deets *Executive Director*

The American Association of Retired Persons (AARP) representing Americans age 50 and above appreciates this opportunity to share its views on the FY 1990 Medicare budget. The budget and deficit reduction continue to be issues which AARP members see as major concerns. In fact, in our last member survey, 66 percent rated deficit reduction as "one of the most important issues or problems" facing the country. This concern is not surprising since older Americans express fear that continuing large deficits will weaken the economy overall and also are deeply concerned about passing on a legacy of debt to their children.

At the same time, older Americans are concerned that federal programs which meet the needs of individuals, old and young, are not being adequately funded. Of particular concern are those programs which serve those who are economically vulnerable. In addition, AARP members (like Americans of all ages) express a strong desire to protect Social Security and Medicare.

AARP has long supported responsible deficit reduction and hopes to work with the Administration and this Committee in continuing this tradition. The Association believes that we all must continue to promote responsible, fair and effective deficit reduction -- deficit reduction which share the burdens, takes into account previous sacrifices, and recognizes that progress will be minimal if we only focus on the spending side of the ledger.

Some have argued that what we need is a dramatic bold stroke. Putting aside whether that would be good for the economy, it is far more important to have a predictable and steady deficit reduction strategy which reduces the deficit gradually. Such an approach should remove, over time, the Social Security Trust Funds from the deficit calculation.

Prior to examining in detail the subject of this hearing -- the FY 1990 Medicare budget -- we would like to express some general concerns about the budget proposals submitted by President Bush. First, the overall structure of the budget puts many domestic discretionary programs which assist lower income Americans at risk, since most of these programs are in the "black box" (the group of programs to be frozen at last year's levels or cut to make room for program expansion). These programs, such as the Low-Income Home Energy Assistance Program (LIHEAP) have already been significantly reduced. (Since 1985, LIHEAP has been cut more than 40 percent.) Using the criteria of both fairness and recognizing past sacrifices, these domestic programs should not be slated for cuts.

Second, even programs in the "black box" which are not identified for further cuts will face real reductions under the Bush proposal. The budget calls for a nominal freeze in these programs, leaving them at the same dollar levels as in FY 1989. In contrast, the Bush request for defense is a "freeze" at a level that includes an inflation adjustment. A nominal freeze on domestic programs means that they will not be able to provide the same level of service in FY 1990 as they provided in FY 1989.

Third, the "black box" includes administrative expenses for the Social Security Administration (SSA). SSA has already absorbed a staff cut of almost 17,000 in the past four years. There is increasing concern that SSA cannot adequately serve the public at current staffing levels and that further cuts would simply amplify existing problems. Further, reducing the administrative expenses associated with the Social Security Trust Fund reserves and does not free up money for other programs.

Finally, the budget continues the request to freeze federal civilian and military retirees' Cost-of-Living Adjustment for one year and then reduce the COLA by one percent a year for the following two years. This is a fundamental breach of faith with these retirees. Further, these types of proposals fail to recognize that a COLA is not a benefit increase, but rather the only way that retirees can maintain their purchasing power.

Before addressing the Administration's proposals for Medicare we would like to comment on the Administration's Medicaid proposals.

MEDICAID

President Bush's budget calls for improvements in Medicaid to reach more poor pregnant women and young children. Under current law, states are required to phase in Medicaid coverage for all pregnant women and infants below the poverty line. The Bush budget proposes to extend mandatory coverage for pregnant women and infants up to 130 percent of poverty.

At the same time, however, the Bush Budget fails to include any new funds to cover these expansions. Every dollar in increased Medicaid funding to cover these expansions is offset by a dollar in Medicaid cuts. As a result, the total amount requested is the same as the amount the Office of Management and Budget (OMB) has said is needed to fund Medicaid under current law without any expansions.

This would have the effect of reducing Medicaid payments to states by $340 million and in turn use all of these Federal savings to finance improvements in coverage for pregnant women and children. This proposal would force states to bear the entire cost of the required improvements. In the absence of additional funding, our fear is that states would be forced to cut back on other aspects of their Medicaid programs to bear the costs of needed improvements.

MEDICARE

The Bush Budget proposes $5.2 billion in Medicare cuts in 1990. Sixty percent of the reductions would be made in Part A with the remaining 40 percent from Part B.

Since 1980, concerns about the economy and the deficit have driven Federal-policy makers each year to take steps to curb the rate of increase in spending under Medicare. Initially, most of this effort focused on the hospital portion of the program resulting in the creation of the Prospective Payment System (PPS). Part A continues to increase at about 10 percent annually. However, Part B which has also been the subject of cost containment efforts continues to increase at an annual average rate of 17 percent.

The foremost consideration must be access to affordable quality health care. Any cuts in Medicare must be undertaken with this in mind. Given the fiscal constraints of the budget and continued growth of Medicare, it would be unrealistic to think that Medicare would not be subject to some cuts. Therefore, the question we must confront is the extent and nature of the cuts.

Projections concerning the solvency of the HI Trust Fund show improvement, but Part A will require continued close oversight to assure that Part A remains solvent. But to affect long term reduction, Medicare's Part B is where much of the work must be focused. However, changes in Part B should not be just for purely cost containment. We must begin to seriously address payment reform and create a more rational, equitable and fair payment system that also slows the rate of increase in costs.

The following sections outline areas which warrant attention. Reductions in Medicare must be viewed in the context of a larger package which assumes constraints in defense spending as well as other domestic spending and additional revenues.

PART A OF MEDICARE

Part A has borne most of the recent Medicare budget cuts. The Association does not believe that Medicare should assure providers a sure return on investment, rather it is our policy that Medicare rates should be sufficient on average to compensate providers fairly for service to Medicare beneficiaries.

Indirect Medical Education

Reductions in Part A should be evaluated carefully for their potential impact on access and quality. However, it is difficult to assess the direct beneficiary impact of some proposals. In those cases, AARP urges Congress to act cautiously and not to make radical reductions.

For example, President Bush's budget recommends severe and immediate reductions for indirect medical education payments. This proposal could threaten the viability of institutions which provide the highest levels of care to the sickest patients. However, a gradual reduction in the indirect medical education payment as recently proposed by the Prospective Payment Assessment Commission (PROPAC) should be considered.

Hospital Capital Payments

Similarly, continuation of the 15 percent reduction in capital payments may be warranted, but increasing the rate of reduction to 25 percent as proposed in the Administration's budget, could prevent needed rehabilitation of the deteriorating physical plants of our large city hospitals. The capital payment system should be reformed to remove incentives toward unneeded capital expansion. But an overall deep cut in capital reimbursement would prevent needed rehabilitation in addition to unneeded expansion.

Update Factor

This year PROPAC again has undertaken a careful analysis of the factors affecting the hospital's cost of providing care, in order to recommend to Congress an appropriate adjustment to the Diagnosis Related Group (DRG) rates. PROPAC's analysis factors in the increase in the hospital market basket (the price of goods and services the hospital must purchase to operate), the differences in operating costs between urban and rural hospitals, costs of new technology, and reduces the total by increases in hospital productivity, changes in case-mix and a reduction for prior overpayments.

Rural and inner city hospitals are of particular concern to AARP. These hospitals which serve disporportionately high numbers of Medicare patients, have suffered the most severe losses and some have closed. Although some hospitals should close, we are concerned about closures which cut off access to care for less mobile persons. Therefore, AARP supports PROPAC's recommendations concerning the hospital update factor.

Based on its analysis, PROPAC is recommending an average hospital update factor of 4.9 percent which is slightly less than the increases in the hospital market basket. PROPAC further breaks down its recommendation into separate amounts reflecting the different costs in rural, large urban and other urban hospitals. The recommended update is 5.6 percent for rural hospitals, 5 percent for large urban and 4.5 percent for other urban hospitals. AARP urges Congress to consider this proposal seriously.

PART B OF MEDICARE

The Effect of Part B Growth

Part B, despite efforts to control costs, continues to be one of the fastest growing domestic programs, growing at an average rate of 17 percent. General revenue financing of the

Supplementary Medical Insurance (SMI) Trust Fund protects it from insolvency, but the rapid infusion of general revenues and escalating premiums into the SMI Trust Fund strains the Federal budget and beneficiaries alike. The growth of the program is attributable both to price increases and increases in volume and intensity of services per beneficiary.

Beneficiaries have strong reasons to support further actions to control spending in Part B. Despite cost containment efforts, beneficiary out-of-pocket costs continue to rise rapidly. Annual Part B premiums have increased 91 percent since 1984 -- from $175.20 to $334.80 exclusive of the monthly catastrophic coverage premium all Part B enrollees will pay. Coinsurance amounts continue to escalate. Aged beneficiaries paid over $7 billion in coinsurance alone in 1988. From 1981 to 1987, coinsurance increased from $2.1 billion to over $6 billion.

Past Cost Containment Efforts

Since 1984, Congress has been driven by the need for budget savings from Part B. Congress froze physicians' fees for almost two years. Yet expenditures continued at double digit rates. In 1987, Congress gave the Secretary of Health and Human services authority to reduce Medicare payments for certain services which are determined not to be "inherently" reasonable. Congress also ordered reductions in reimbursement for a specified list of "over-priced" procedures, most of which relied on technology and were surgical procedures.

The Bush Budget Proposals

The Bush budget proposes reducing payments to providers by $2 billion and raising $600 million by continuing the requirement that beneficiary premiums equal 25 percent of Part B costs.

As we have outlined above, increases in the Part B premium and the amount paid through coinsurance are straining the pocketbooks of Medicare beneficiaries. Of particular concern to AARP is the Administration's proposal to extend the requirement that premiums equal 25 percent of Part B expenditures. This requirement is due to expire at the end of this calender year.

The Association does not support the extension of the 25 percent requirement. While beneficiaries want to pay their fair share of Medicare costs, they cannot be expected to continue to pay 25 percent of a liability over which they have no control. Although the hold harmless requirement does not permit a beneficiary's Social Security check to decrease, a growing number of beneficiaries are seeing their cost-of-living adjustments wiped out by the increases in their Part B premium.

The Administration achieves further savings in Part B through a freeze on the Medicare Economic Index (MEI) and reduced payments for radiology, surgery, and anesthesiology; "over-priced" procedures; and limiting reimbursement for new physicians.

Past history has shown us that when physician's fees are frozen or reduced, savings have been diminished because of an increase in the volume of services performed. Some suggest that the increase in volume is beneficiary induced. The Association believes, that the doctor, not the patient, is still the decision maker when it comes to ordering tests and performing procedures. Thus, the direct beneficiary impact of price reductions and freezes is increased out-of-pocket costs through premiums, coinsurance amounts and balance billing.

Because we do not yet have concepts developed to address the volume issue, Congress has little choice but to take steps toward reducing prices of some services and controlling overall increases in prices. AARP supports the concept of reductions in "over-priced" procedures with investment of some of the savings in currently "under-valued" services such as primary care. This would be in keeping with past actions of Congress. We would like to point out that when savings are reinvested in "under-valued" services such as primary care, beneficiaries pay more for those services through their coinsurance.

When Congress has reduced prices of specific services, limits on balance billing have been put into place to prevent cost-shifting to the beneficiary. We urge Congress to continue to follow this concept. In addition, the limits placed by the Maximum Allowable Actual Charge have held balance billing relatively stable over the past couple of years. We believe that beneficiaries should share fully in the savings we achieve in the budget, and not bear the burden through cost-shifting.

We must achieve realistic savings from Part B -- but we must begin to address the broader issue of Part B reform in order to assure that Medicare provides access to doctors' services and costs are controlled. The goals of budget deficit reduction efforts must work consistently with the goals of reform.

THE FUTURE OF PART B

In enacting budget reductions in Part B, AARP asks Congress to also examine the issue of Physician Payment Reform. As you know the Physician Payment Review Commission will be reporting to Congress in April with recommendations for reform. Beneficiaries and doctors need reform of the system to assure access by bringing rationality to the payment system and to achieve cost containment.

Reform will often be discussed in terms of the impact in the aggregate. Patients do not visit a physician in the "aggregate". Patients encounter specific medical problems and need to see specific physicians.

Resource-based Relative Value Scale

The Association has long supported the concept of the resource-based relative value scale as a method to achieve fair and rational payments for doctor's services. Information from the recently completed Harvard RBRVS suggest that major changes in relative values among certain classes of services are warranted. However, if implemented rapidly, these changes could be expected to lead to serious strains on the existing financial protection features of Medicare.

Substantial fee reductions would almost certainly lead some physicians who now participate in Medicare to abandon their participation agreements and non-participating physicians who now accept assignment on some Medicare claims would also be expected to reduce their willingness to accept assignment. Thus, the Association supports a transition of at least five years to insure that neither patients nor doctors experience sharp increases or decreases.

In contrast however, the Harvard study shows a number of services which are undervalued and the payments for them should be significantly increased. Obviously this poses certain issues for beneficiaries. First, increased payments for primary care services which may be more appropriate care for an older patient, poses disincentives to the patient in the form of higher coinsurance. Yet higher payments may increase assignment and participation rates.

Therefore, in judging the impact of major payment changes on beneficiaries, AARP will examine carefully the trade-offs between overall costs for physicians' services borne by all enrollees and the cost effects on those enrolles who actually receive services.

Volume Issues

An RBRVS alone will not address the increase in volume. Little is known concerning physician decision making under an RBRVS-derived fee schedule. Decreases in fees for some services may result in some efforts to increase volume to offset reductions in income that would otherwise occur. On the other hand, increase in the prices of other services may stimulate an increase in the supply of those services. As stated previously, the doctor, not the patient is the decision maker concerning the ordering of tests and performing procedures.

Addressing volume concerns is an extremely difficult task. There is virtually unanimous support among all of the parties concerned with Medicare spending about the benefits of deterring payments for unnecessary services. We must take steps to better determine what is necessary and appropriate for quality patient care.

Practice Guidelines

One of the goals for physician payment reform should be an increase in the cost-effectiveness of care. Over the years, the volume of procedures and services provided per Medicare patient has steadily increased. There is no evidence to show that the procedures performed have had little if any value in improving the health or equality of life for Medicare patients. Thus, one objective of payment reform should be the redirection of the distribution of medical services so that the services delivered are concentrated among the more effective ones and fewer less effective services are delivered.

While an RBRVS may help in redistributing care in theory, by removing financial incentives of the current system to perform surgery and invasive procedures, AARP believes the development of practice guidelines are necessary and continues to support research of patient outcomes. Investing resources in the development of practice guidelines is an important first step in discriminating among effective and ineffective services.

The development, implementation and, success of practice guidelines are dependent upon the medical community. Without the investment of each physician, volume will continue to grow unabated. If volume continues to grow, doctors must be prepared to accept measures which are far more intrusive.

Expenditure Targets

The newest proposition for dealing with the volume issue are expenditure targets or caps. Under this approach, where caps on allowed expenditures for doctors' services are exceeded--because of price changes or because more than the expected number of services are provided -- a plan goes into effect to reduce rates of payment to providers. It is not yet clear, however, exactly how any plan would work, how expenditure ceilings would be established and enforced, who would be responsible for enforcement and the implications of any reductions on patient access to various services.

While expenditure targets may be supportable, AARP is concerned that this step not be taken until more data is available on how this approach would effect access to care for the entire population. For example, all other country's which approach expenditures in this manner have national health insurance. In this country we have many purchasers of health care. How would expenditure targets in place in Medicare effect the cost and access of care for those not covered by Medicare? Would the savings achieved by Medicare by this approach be shifted to the working population by increased prices -- thus making employer-based health insurance even more expensive?

Conclusions

Recent budgetary constraints on doctors' services have been accompanied by enhanced beneficiary protections in the form of increased assignment, balance billing limits. These policies provide a structure from which reform of Part B can take place.

However, strategies to reduce the deficit by controlling only the price of services will not ultimately continue to assure access to appropriate care and will not be successful because of the unabated growth of volume. Thus the costs of the program for beneficiaries whose premiums and taxes help fiance Medicare will continue to increase rapidly as well.

To achieve more effective controls over spending new policies will be needed to address the volume issues. Volume is a more troublesome and sensitive area to address. The search for budgetary savings during 1989 will probably take priority over a more deliberate approach toward physician payment reform issues. The longer-range reforms will require more careful research and further analysis before all their implications for beneficiaries and patient are understood.

The challenge is to find a balance that fosters access to affordable quality health care while prudently controlling increases in health care costs. The Association looks forward to working with Congress towards this goal.

Chairman **Sasser**. From an objective, dispassionate hearing of your testimony here, I take it that it is the consensus of this panel that we are not seeing a kindler, gentler budget as far as medicare is concerned. That seems apparent to me.

Is that correct, Mr. Casey?

Mr. **Casey**. Yes, sir, it is.

Chairman **Sasser**. Well, let me just ask you this: Mr. Casey, what do you speculate might happen to hospitals if the new Bush medicare budget proposals are enacted?

Mr. **Casey**. Well, unquestionably, Mr. Chairman, the hospitals in the coming immediate year would suffer further losses. In our own system, we estimate that to be just under $5 million, if this budget were enacted.

Probably, though, of more serious concern is what happens if in fact that budget philosophy stays in place over a period of years. I do not know how many hospitals in this country are on the brink or operating at such margins that they could not withstand the further 5 percent reduction at this point, so I cannot specifically answer your question. I think clearly there are some that would suffer irreparable harm, and all hospitals would suffer relatively to some extent.

As was previously mentioned, however, in the prior panel, there is wide variability on hospitals' current financial condition and operating margins, both within these programs and in general, and so the effect would obviously be variable, depending upon that.

Chairman **Sasser**. Now, in your own system, you have both what I would characterize as rural hospitals and urban hospitals. Is that a fair statement?

Mr. **Casey**. Yes.

Chairman **Sasser**. Now, which would be impacted most adversly, from your own experience in your own system by these cuts? Would your rural hospitals be hurt more, or would your urban hospitals be hurt more or would they be hurt an equal amount?

Mr. **Casey**. Clearly, in our case, our rural facilities would be hurt disproportionately. That has to do—that is a very complex question, in the sense that location is only one of several variables that determine whether one does relatively well or relatively poorly under the current reimbursement system, one of the main variables being case mix, because certain diagnostic categories carry better payment with more margin in them, frankly, than do others.

For instance, our urban hospital, as is the case in our case, we have a very high percentage of sophisticated cardiovascular work, including——

Chairman **Sasser**. In the urban hospitals?

Mr. **Casey**. Yes, and it happens to carry a relatively good payment under the DRG system, so if we do more of that we do better. We do very little of that type of work in our rural facilities and do a great deal more of the primary and secondary level work, which is relatively less well-paid.

Chairman **Sasser**. From a financial standpoint, what procedures do you receive less remuneration for or make less profit on?

Mr. **Casey**. I really could not speak to that, Mr. Chairman. There are several thousand of those, and I think it also varies considerably by geography around the country.

Chairman SASSER. Hospital to hospital.

Mr. CASEY. Yes.

Chairman SASSER. We hear that there is excess capacity in the hospitals. We have heard that this morning from the Secretary of Health and Human Services and we heard it from the panel previous to yours. What is a normal occupancy rate now, and how does that compare with the past?

Mr. CASEY. I believe that across the country the figures that were given earlier are very accurate, approximately 60 percent in most of the urban areas and somewhere in the 40 or 45 percent area in rural facilities. That is consistent in the case of the rural hospitals with our area of the country. Our urban facilities, for other reasons, tend to run a little higher. But in both cases, certainly compared to history, those occupancy rates are low.

However, if I may expand on my answer to that, I think there are some prevalent myths about the impact of that reduced occupancy or apparent lack of use of fixed physical plant facilities. I think you would find, particularly in the case of the larger urban facilities, that that space does not tend to go unused. In almost all cases that I am personally aware of, at least, alternative uses for that space have been found so that it does not sit stagnant. Other levels of care, the addition of residentially oriented programs, outpatient oriented programs tend to come in and fill that space, skilled nursing facility types of programs, et cetera.

In any case, I feel the need to point out that, even were that not true, even where some portions of those facilities are used, there is no evidence, statistically or financially, that I am aware of, that would prove that that costs the system a great deal more.

We do not staff unused beds. Most of the costs associated with operating hospital facilities is in the labor area, and we staff our facilities consistent with the intensity of the services being provided to the real patients that are there, not to empty beds, and so there is a very small marginal and incremental cost to empty hospital facilities, until you close the entire facility, which obviously does reap savings.

Chairman SASSER. So, am I to understand, at least from your personal experience, that over-capacity is not that expensive for the hospital? In other words, are these folks who say that one of the principal problems with hospitals is they have got over-capacity, are they going down the wrong track on this?

Mr. CASEY. I believe so, yes, I do, Mr. Chairman, especially that is true when they are talking about only portions of the facilities. As I mentioned, I do think that there is some over-capacity in our hospitals, and in spite of the difficulties around the issue of closure of hospitals or at least inappropriate closures, there certainly could be a case made, and I think a fair one, that some hospitals in this country needed to close and probably there are still some that selectively need to close.

The problem that we have is that random economic closures or economically forced closures due to an unsatisfactory reimbursement system is not the way to properly select which hospitals should close.

Chairman SASSER. I think that is a very wise observation and I could not agree with you more.

One final question—my time is up and I want to yield here to Senator Exon. As I understand you, Mr. Casey, when.you have got 60 percent utilization of your hospital, in the hypothetical, you do not keep it staffed up for 90 percent utilization, you try to staff it for 60 or 65 percent utilization, is that correct?

Mr. CASEY. That is absolutely correct. In fact, on a national level, I believe that it is stated in the document that you were given that full-time equivalent employees per equivalent occupied bed have stayed constant throughout the implementation of the PPS system, in spite of the fact that intensity of services has gone up significantly during that time, so there actually has been productivity improvement.

Chairman SASSER. That is very interesting. I want to return to that more, but I will yield now to Senator Exon.

Senator EXON. Mr. Chairman, thank you very much. I would like to thank the witnesses for coming here this morning. This is a very, very important matter, as you can tell from the questions you have been asking, the attention that we are giving this on the Budget Committee.

I am going to ask each of you a Budget Committee question that may not be entirely fair, but it helps us make decisions here. If each of you had to make the decision that we have to make here, would you be in favor of waiving the Gramm-Rudman-Hollings sequester if we found it necessary to fund medicare at the level, the minimum level that you think is necessary?

Mr. CASEY. Yes, sir, absolutely. In fact, that is one of the recommendations in the AHA position paper.

Senator EXON. Doctor?

Dr. SCALETTAR. I would think that type of action would hurt the public health service programs considerably.

Senator Exon. What would hurt the public health services?

Dr. SCALETTAR. They would be taking a disproportionate loss.

Chairman SASSER. You mean if we went to sequester, Dr. Scalettar? Does everybody understand what sequester under Gramm-Rudman-Hollings means? That is kind of a term of art.

Senator EXON. Sequester under Gramm-Rudman-Hollings provides that there shall be a proportionate cut in selected portions of the budget if we do not meet our targets, and by selected portions of the budget I mean about 60 percent of the budget is off-limits and therefore we would be applying the cut to the balance.

My question then is that if we had the option of eliminating that sequester to provide the monies necessary so that what you think is minimally necessary to fund medicare—and the answer by Mr. Casey was yes, definitely, yes we should.

Mr. CASEY. Senator, I am sorry, I have to retract my answer. As I often do, I answered too quickly. Because for the same reason that the doctor suggests, the American Hospital Association position would be that, while selfishly for the hospital sector of the industry, that would be a positive thing for you to do, it would certainly create concerns for us about the greater impact that it would have on other parts of the health care delivery system, including the public health system, and so we believe that there would be difficulty with that solution, unfortunately.

Dr. **Scalettar**. I think Mr. Blehart would like to respond to that question.

Mr. **Blehart**. That indeed is part of the problem of sequester, in that it looks like a very easy answer. But, when you look at what that does for the public health service elements of the HHS budget in particular, it has the potential of decimating those programs by eliminating people who are doing essential research. Indeed it certainly does help the hospital and the physician components of medicare and it is a very selfish answer to say, "yes, that would be the route to go." But for the overall down-the-road impact on the overall economy and the overall budget, it is not really the most workable solution.

Senator **Exon**. Well, I am afraid that the panel—we are talking different languages. Under the present system, if we give you the money that you think is necessary for medicare, and if that would throw us over the budget, then my question was would you be in favor of waiving the automatic cuts under Gramm-Rudman-Hollings so that we could finance what you think is minimally necessary for the programs you are talking about here today.

Dr. **Scalettar**. The answer is yes. [Laughter.]

Senator **Exon**. Thank you.

Dr. **Scalettar**. Now I understand your question.

Ms. **Burgess**. AARP has opposed the sequester mechanism overall, to begin with, but medicare is partially protected in a sequester, and there is cost-shifting to patients under a sequester.

Senator **Exon**. I suppose this question should be directed probably to you, Ms. Burgess, but if the other health care delivery experts care to comment on it, I would welcome it.

The catastrophic health care program was added last year, as you all know very well. In recent months, a number of seniors have expressed concern about the financing methods. Now, I have some concerns about this, after supporting the program, and I am looking for some possible option. How does the panel react to these concerns expressed by a large number of senior citizens, and is it appropriate in your view to take another look at the method of financing the catastrophic health insurance program that we did enact last year?

Ms. **Burgess**. Mr. Chairman and Senator Exon, I am pleased you ask the question. I expected it. My phone is very busy a good share of the time and I get a good many letters. I would have to tell you that I think it is a very vocal minority, mostly people with $30,000 and over in income who are really letting you know that they are unhappy with the financing.

As you know, AARP did not support this kind of financing, but we truly believe that the benefits are worthwhile. The silent majority out there are just not saying very much, as usual when something like this happens. But I would have to tell you that in my own family, my husband's 97-year-old mother could have used the catastrophic legislation a great deal last year and she will be using it this year. I have two very close friends whose spouses are in nursing homes and they will certainly benefit from spousal impoverishment. I have a very close friend whose parents will benefit from the pharmaceutical provision.

We have not had a lot of attention to the benefits, but they are there and they are good, and I think it is extremely important that we hang onto those benefits. I think it is extremely important. It is a part of the total piece, and the other two pieces I think, since I have the floor and will be able to say this, are long-term care for everyone, not just for the elderly, and universal access to care.

I think it is a disgrace in this Nation that we have 37 million people without health insurance, and almost 12 million of those are children, and I think we really have to look at our total system and see how we can work it out so that we can put all the pieces together. Let's do hang onto those benefits in catastrophic. What you do on the financing, I do not know. It is not easy, with the Federal deficit, I know that.

Senator EXON. Certainly not, and the basic thrust of my question was that I think we very much need the programs. I was asking about the financing part of it, and you have—in other words, you say keep the program; if we want to change the financing arrangement, you have no quarrel with that?

Ms. BURGESS. It would depend on how you do it, I suppose. There were some options that AARP suggested and I think they were not acceptable to Congress, but certainly you may be looking at that part.

Senator EXON. Do either one of you care to comment on that?

Dr. SCALETTAR. We supported the catastrophic bill last year and we have no reason to change our position. We certainly are in favor of the bill.

Mr. CASEY. The same.

Senator EXON. May I ask one more question. There seems to be a failure in Washington, at least, to understand and recognize the special problem—and I think there are some special problems—of the health care needs in hospitals in rural America. Rural reimbursement rates are not realistic, given the large share of medicare patients in rural hospitals. In other words, let us take Nebraska, for example. We have a heavy concentration of senior citizens and, more important than that from a statistics standpoint, even a heavier share of those live in the rural areas, therefore I think we can prove that the reduction in medicare that is being proposed would have a really critical effect in Nebraska.

We had testimony this morning, and I believe it was from North Dakota, if I remember right, that 80 percent of the people that use a certain hospital—was that North Dakota, do you remember?

Chairman SASSER. Yes, it was.

Senator EXON [continuing]. 80 percent of the people that use a hospital in North Dakota were medicare recipients, and therein lies a problem that Washington doesn't seem to realize. All hospitals do not treat, obviously, the same percentage of people from the various age groups, and therein lies a particular problem where we have a concentration of elderly citizens that rely on medicare.

Do any of you have any views on that problem, or have you ever looked at it?

Mr. CASEY. Yes, sir, I look at it every day. In our facilities—and you are absolutely right—our rural facilities particularly in my own system have as high as 85 percent of their patient base out of the combination of the Medicare and medicaid programs, but most often the vast majority of those are from the medicare group.

To exacerbate that problem, especially in the rural areas, the 15 percent or so that remains is not made up of well insured private payers. It is often made up of people who fall through the cracks of the system and cannot pay at all, and that is, of course, the specific reason why our rural facilities do not fare nearly as well as our urban facilities, and obviously, as the funding mechanism continues to deteriorate, as it would under this budget proposal, that problem is compounded each year.

Senator **Exon**. Doctor?

Dr. **Scalettar**. Senator, not only do the facilities have problems, but rural physicians are severely impacted. They are being reimbursed at a 1971 based level and with the rates of increases medicare charges are much different from what they charge nonmedicare patients. Therefore, they are really under the gun, because their professional liability fees have gone up, their ability to pay their rent for their offices is diminished—and I know physicians in Nebraska and in Tennessee and in northern Minnesota, and they are severely under the gun. This is one of the reasons why we have put forth this resource-based relative value scale, so we can address this issue of physician reimbursement, particularly with its geographic variations. This is a very severe problem.

Senator **Exon**. Ms. Burgess?

Ms. **Burgess**. In New Mexico, we really have a problem as far as rural hospitals are concerned. We are much concerned about it, because the distances are so great there and the elderly people really will not have access to health care and the needed doctor and hospital services, unless there is a doctor there and unless there are hospitals there. So it is a real concern.

Senator **Exon**. As I said this morning, you show me a community that does not have a hospital and I will show you a community that does not have a doctor or does not have one for very long. It is a very serious problem.

The panel has been very informative and helpful. I thank them and I thank you, Mr. Chairman.

Senator **Sasser**. Thank you very much, Senator Exon.

Let me just follow up on something Senator Exon asked you, Mr. Casey, with regard to the medicaid system. In Tennessee, can you break even on medicaid payments in your large hospital there in Memphis?

Mr. **Casey**. No, sir, there is simply no way. It pays at roughly, if I am not mistaken, off the top of my head, something less than three-quarters of our actual cost of providing service.

Chairman **Sasser**. So, every time you treat a medicaid patient, you figure you are losing 25 cents out of every dollar's worth of care you give him?

Mr. **Casey**. Yes, sir, and that is on a cost basis, not a charge basis.

Chairman **Sasser**. On your cost basis.

Mr. **Casey**. That is correct.

Chairman **Sasser**. Well, in this budget that is before us, medicaid could end up with some cuts itself. Could you swallow another——

Mr. CASEY. My understanding, Mr. Chairman, is that those cuts are directed at the administrative fees——

Chairman SASSER. Correct.

Mr. CASEY [continuing]. Or whatever that are given to the States, and I am not conversant with how dependent the State is for that money, but that actually that money would be left in the system on a "budget neutral" basis in order to open the door to approximately 150,000 new beneficiaries nationwide, particularly pregnant women and infants.

While we find that philosophy commendable on President Bush's part to expand the eligibility for that program, because certainly many of those 37 million people mentioned earlier are the ones who fall through the cracks on the medicaid program, we do find it troubling, quite frankly, or at least questionable that the mechanism that eventually ends up in a budget neutral position is sufficient to provide access to that many new eligibles in the medicaid system.

Chairman SASSER. Well, if the administrative reimbursement to the States for administering the medicaid program is cut, how is that going to impact on the medicaid program, in your judgment, in the State of Tennessee?

Mr. CASEY. Quite frankly, I am not certain, because I do not know what authority the State has to in turn pass that loss on to the providers. If they were prevented from doing that, it may in fact not have a negative impact, but I am not certain of the answer.

Chairman SASSER. Ms. Burgess, I want to take this opportunity to say that I think the AARP has taken a very responsible leadership position on the whole question of medicare catastrophic benefits and how they are to be financed, and you are quite right, we really need to do a better job of letting the beneficiaries know what this catastrophic coverage will do for them. Ninety-eight percent of them now, all they know is it is costing them more money.

I held a series of lengthy hearings across my State over a period of 2 years, taking testimony from various and sundry individuals who had been hit with catastrophic illness, and I can guarantee you that those children who were trying to care for a mother or a father or an aunt who had a catastrophic illness, or that wife whose husband had been hit by a catastrophic illness would have literally jumped at the chance to have the kind of coverage that was enacted here in the Congress.

That is not to say there are not a lot of problems with it. I frankly think it needs to be much, much broader, and perhaps we do need to tinker with the way that the premiums are paid. But there just is no free lunch these days anywhere around, and there is not going to be one in the field of health care, I do not think, any time in the very near future, and people are going to have to become acclamated to picking up some of the cost for the extension of these various and sundry benefits.

Dr. Scalettar, I want to touch on sort of a touchy issue here now. A moment ago, we heard one of our witnesses testify that the volume of services per medicare enrolle being given by physicians was doubling, I think every 10 years, and I am sure you could give us reasons for that. But do you believe that all these volume increases are necessary?

Dr. SCALETTAR. Well, as I——

Chairman SASSER. What do you say to the observation that some physicians are increasing their services simply as a way to maximize reimbursement, as others are telling us?

Dr. SCALETTAR. First of all, if there are any unnecessary services, we are clearly against that. The fact is that health care economists frequently address situations and they do not know what the practice of medicine is. As we have an aging population and as they have more and more problems and they come to the doctor's office, as they do to mine, they have newer complaints and newer problems and we have to address them. Just as Ms. Burgess said she does not want to be taken care of in the "aggregate," we take care of individuals. And when my patients complain about a new problem, they have to be taken care of.

We do not interpose ourselves in the doorway and say "do not come to the office." The patients schedule an appointment and they come in because they are sick. When they come in because they are sick, they may require more diagnostic studies that, fortunately, technological advances allow us to do. So, I think the concept of unnecessary services is blown totally out of proportion and is really based upon the fact that we are technologically much more sophisticated.

Another aspect of this is that part A and the DRG's have caused more services to be performed outside of the hospital, with many being performed in hospital outpatient departments, so that 28 percent of the recent growth in medicare part B services is due to procedures and facility use in the hospitals, such as cataract surgery, endoscopy, or gastroscopy.

I think the entire concept of unnecessary services, if they exist, we are obviously against it. This is why we have banded together with Rand and others, such as the Joint Commission on Accreditation of Health Care Organizations, to go into quality assessment, so that we will have a better idea as to what the parameters are that physicians can follow prospectively.

Finally, I have never had a patient to whom I explained that we have a need for this procedure or this diagnostic study tell me do not do it because I want to save medicare Part B money.

Chairman SASSER. I suspect you never will have one, either. [Laughter.]

Doctor, the Department of Health and Human Services is embarking on some new medical effectiveness research that is supposed to tell us something about which new procedures are really effective and, as I interpret it, whether or not are worth what they cost, in other words, a cost-effectiveness study or a cost-benefit ratio study, if you will, on medical procedures.

Do you have any perspective that you would wish to share with us on this research?

Dr. SCALETTAR. Here, too, our liaison with Rand will help us as well. The Joint Commission, of which we are members, will also be studying outcomes. We want to certainly know more about any cost benefits and give what is optimum care to our patients.

Certainly, if we discover that a procedure is being over-utilized and not achieving any benefit, there is no reason to do it. But right now, as we advance into medical technology, we can find that an MRI scan of the knee may obviate doing an evasive procedure like an arthrogram. We are learning more by all of the technological advances, and there are more coming down the pike which are going to be very costly, but may increase the ability of our patients to live longer.

Mr. BLEHART. In addition to the need for more of this effectiveness-type research, the AMA does support the HHS budget spending some of their money for more effectiveness research. But, there has to be caution that the research cannot all be focusing on the cost versus the effectiveness, while you can look at something and try to put a dollar value on it versus a health care value, the dollar value may be quite high and the health care value to the individual may also be quite high.

So, it is a very difficult matter, and a balancing type act must be done. We believe that these sorts of research activities will really work hand in hand with the activities of the AMA in the development of practice parameters.

Chairman SASSER. Let me direct a question to you, Mr. Casey. We have heard a lot of conversation about a wide variation of hospital margins, some hospitals operating in the black, others operating in the red, some breaking even. Which hospitals are likely to be in better shape financially, and why?

Mr. CASEY. That is a difficult question to give a straightforward answer to. I think there are two primary variables. One, quite frankly, is that there are different levels of quality of management in facilities and different practice patterns on the part of physicians in various geographic regions of the country, urban versus rural, large versus small, et cetera, which definitely impact the ability of that hospital to be cost-effective. Obviously, physicians dictate to a great extent the resources utilized within the inpatient setting, and therefore how well a hospital does economically under a fixed-price payment system.

Secondly, however, is the factor that I mentioned earlier, and that has to do with the fact that the DRG system itself has not been monkeyed with very much since its inception six years ago now, in terms of recognized differences of margin or profitability that are built into the payment system by different diagnostic category. So, if you happen to be in a facility that does a high percentage of procedures which happen to fall into the more profitable category, obviously you are going to have a higher margin.

The other difference and maybe the most important difference, is the level of dependency on the medicare and medicaid programs. A facility that has a 30 percent base in medicare, for instance, obviously is much less susceptible to the volatility of this program than one which is 80 percent, and there are those kinds of swings in dependency as well.

Chairman SASSER. Well, I want to tell our panel that we very much appreciate your presence here today and your participation and your observations. You have been very patient. You have been here for 2 hours and 10 minutes, and so that the committee will not be accused of cruel and unusual punishment, we are going to bring these proceedings to a close.

I do want to express my appreciation to you for attending here today, and particularly you, Mr. Casey, coming all the way from Memphis to ably represent the American Hospital Association.

Thank you, and these proceedings are closed.

[Whereupon, at 3:45 p.m., the committee was adjourned.]

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